REVIEW
OF
PRE-HOSPITAL CARE
PROVINCE OF BRITISH COLUMBIA

Prepared by: J. V. Cain, Chief Coroner
On behalf of: Ministry of Health

July 31, 1989

89-05862/

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INTRODUCTION

On April 26, 1989, the Deputy Minister of Health, Mr. Stan Dubas, requested the Chief Coroner of the Province of British Columbia, Mr. Vincent Cain, to "review the provision of emergency pre-hospital care in the Province of British Columbia." The particular personal selection was based on the independence of the office of Chief Coroner.

This request stemmed from a number of incidents which affected the Emergency Health Services Commission's relationship with some municipalities and agencies, and which was perceived as having a potentially adverse effect on the delivery of emergency pre-hospital care in some sectors of the province. The Deputy Minister's review was "intended to cover all aspects of this area, but not limited to, the agencies currently providing service, their relationships and capabilities."

It was clear from my discussions with Mr. Dubas, that his intent was to ensure the citizens of this province received the most effective and efficient attention during pre-hospital periods of critical illness or injury. No further instruction or direction was provided; no hidden agendas were hinted; I was free to consult and determine as the issues were presented. I was permitted every freedom in searching out the problems and reaching resolutions, and in contacting whomever it was deemed appropriate.

As a consequence, I enlisted the services of Mr. Ray Nelson, a retired police officer who had an extensive operational and administrative background in dealing independently in the public service. Mr. Nelson's added reputation included that of being a person who is helpful to persons in need.

We proceeded to meet with individuals and groups at the political, agency and personnel levels. Without exception, all were honestly candid in sharing their concerns and aspirations, which I must confirm, were in the public interest. Not unexpectedly, some perspectives varied and conflicted, dependent on the particular makeup of the person or agency. Irrespective of that, the one common theme that prevailed throughout was how to best attend to the immediate physical and psychological needs of the citizen in distress. Indeed, that confirmed, it was then necessary to isolate and examine the many subsidiary issues which either complemented or detracted from that central theme.

This report will attempt to do just that, by way of chapter and verse. This is not intended as a "Judicial Inquiry" or an "Inquiry", in the strict sense of those terms. Rather, it was to be an external, administrative and operational examination of the service, identifying problems in this less formal manner, and proposing recommended courses of action which might assist in resolving those difficulties.

GLOSSARY OF TERMS

A.L.S.	Advanced Life Support
B.C.B.C	British Columbia Building Corporation
C.U.P.E.	Canadian Union of Public Employees
E.H.S.	Emergency Health Services
E.H.S.C.	Emergency Health Services Commission
E.M.A.	Emergency Medical Assistant
E.F.R.	Emergency First Responder
G.V.R.D.	Greater Vancouver Regional District
I.F.A.	Industrial First Aid
I.T.T.	Infant Transport Team
J.I.	Justice Institute
P.F.A.	Professional Firefighters Association
P.F.R.	Professional First Responder
W.C.B.	Workers' Compensation Board

Province of British Columbia

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April 26, 1989

TO WHOM IT MAY CONCERN:

Re: Mr. Vince Cain

This letter is to serve as an introduction for Mr. Vince Cain, Chief Coroner of the Province of British Columbia.

Mr. Cain is acting at my request to review the provision of emergency pre-hospital health care in the Province of British Columbia. The review is intended to cover all aspects of this area including, but not limited to, the agencies currently providing service, their relationships and capabilities.

The review will provide recommendations that will serve as a guide to ensuring that the citizens of British Columbia are receiving the most effective and efficient service in time of illness or injury.

Your cooperation in assisting Mr. Cain with his review will be most appreciated.

Yours sincerely,

S. P. Dubas
Deputy Minister and
Chairman, Emergency Health
Services Commission

Chapter 2

HISTORY

Prior to the creation of the Emergency Health Services Commission in 1973, under the provisions of the Health Emergency Act, R.S. Chapter 162, pre-hospital emergency care was a mix of public and private systems. Not without its problems, this nevertheless did provide a service to the public.

Communities in British Columbia first had a level of medical emergency response by way of a St. John First Aid Certificate. Fire services and industry, by way of W.C.B. requirements, later raised this level to an Industrial First Aid Certificate, and beyond, which grew until 1974. The general public were expectedly satisfied with this level of service for it was the state of the art at the time. It was not condemned then and it ought not be criticized now. In the majority of instances it was staffed by citizens, both public and private, who had varying levels of training and expertise, but whose concentration was on assisting the person in need.

An overview of the province will tell the story that expectations were not all necessarily the same. If a person chose to live in a remote area without hospitals or doctors, then he could expect the level of a St. John First Aid Certificate, or if he were fortunate, Industrial First Aid. On the other hand, if he chose to live in a large urban area such as Vancouver, Victoria or Kamloops, near hospitals, he would tend to expect better attention. Of course, as in any system, there are exceptions to the rule.

Prior to the more formal provincial emergency pre-hospital care (ambulance) system, the task of providing this service rested at the municipal level. At that time there were two major, public emergency services: police and fire. The citizens were conditioned to call upon one or the other in these types of situations, and both agencies responded as effectively and efficiently as they were equipped to do. It ought also be recognized, however, that in many of these health care cases, there was no crime, and there was no fire. Nevertheless, respond these two did, and hence an historical public reliance on the two public agencies in pre-hospital emergencies.

Fire Departments were recognized as having taken on this responsibility more zealously than police departments. This again was not an illogical progression, for "rescue, first aid and resuscitation" were an integral part of the fireman's training and provisions. The public looked to the fireman to assume control over "the man down", while the police officer controlled the scene and made way for one who could better assist. That is not to say policemen did not assist or were disinterested. Indeed and contrariwise, the police often were the first responders, providing first aid and transportation to the hospitals. Each case was determined on its own merits, and the circumstances of the moment dictated who would provide the first, and the best, medical attention. Regardless of that, the public came to expect the fireman to be their salvation during those critical moments. When telephoned, the police station or the fire hall, both would respond. Some fire departments, recognizing this need to fill the gap, went the extra mile in para-medical training for their staff.

That is significant from an historical perspective because even today, and even with the emergency page of the telephone book listing the now three emergency services (police-fire-ambulance), many citizens call for the police or fire service in "an emergency." The need is immediate; they want a response right now; and they know that someone down there will sort it out and get to the scene. They have been accustomed in this fashion, and customs are slow to change.

With the creation of the Health Emergency Act, under Section 5(1)(c), the E.H.S.C. was authorized to:

> "assist . . . municipalities and other organizations and persons, to provide emergency health services and to train personnel to provide services, and to enter into agreements or arrangements. . . "

Thus, in 1973-74, E.H.S.C. inquired of the Fire Chiefs Association of British Columbia whether it would be willing to provide ambulance services under such an arrangement. The Fire Chiefs declined on the basis they were primarily fire suppression and rescue oriented. Further, they saw themselves as a municipal agent, responsible to their respective mayors and councils. They envisaged the ambulance service as a provincial emergency service, under a broader provincial umbrella, and thus deferred to that authority.

The provincial ambulance service was thus born and became the "new boy on the block." Now, at fifteen years of age, it is at the stage of puberty. It is comparatively young, both in the eyes of much of the public and the other emergency services. It can go to war, but it's not old enough to vote or drink in the neighbourhood pub. It doesn't have the whiskers yet; it can't shave, and it dasn't cry. That is a perception in some quarters, rightly or wrongly. Having said this, there is a consensus the general public would not accept a diminution of a service which affords them greater opportunities in a medical emergency.

The historical, traditional, customary ways of managing emergency services in this province thus play a major role in assessing and determining the root causes of current problems. Albeit one aspect of this inquiry, it was very significant throughout.

Chapter 3

GEOGRAPHICS

Another forceful circumstance in the examination lay in the geophysical considerations. British Columbia is a huge land mass, with a myriad of distinctions. In providing a "provincial" service, the accent must take into account all those variations. It is not sufficient to hold that every citizen in the province is entitled to the same level of pre-hospital emergency service. The reality of that objective is simply not possible in this province. It's a myth. I think of response times as an example. The scenario is vastly different in the large urban setting when judged against the Charlottes and the Alaska Highway. But that ought not be confused with the standards of care at the scene. Emergency pre-hospital services must take into account many, if not all, of these qualifying factors.

For this reason alone, it is important at the outset to distinguish and separate the provision of emergency pre-hospital care into four major geographic components:

(a) major urban-regional districts;
(b) major municipal-organized districts;
(c) minor municipal-unorganized districts;
(d) rural-unorganized districts.

The needs in each of the above will vary and create distinctively different emergency service responses. Greater Vancouver and Victoria fall into the first distinctive category. The likes of Prince George, Kamloops, Kelowna, Nanaimo, Nelson, Prince Rupert, Terrace, Campbell River, would fall into the second category. And locations like Lake Cowichan, Clearwater, Chetwynd, the Charlottes, Fort Nelson, are likely candidates for the third distinction. Clearly, these are not black and white determinations; rather, they serve as guideposts for establishing needs and services, and public expectations of them. A realistic and pragmatic assessment is paramount to providing this service. The B.C. Ambulance Service addresses this to some extent in its "Response Time" and "station location" determinations.

The point being made here is that local conditions dictate local needs, and even in a unitary provincial system, this must be acknowledged and respected by the population and all agencies. Again, this is not to say the standard of care can be allowed to be lesser; no. It does, however, acknowledge that the level of service may, of necessity, differ because of the geographics.

These aspects shall be considered during the analyses of this report. It is significant to keep these distinctions in mind when considering all the issues surrounding emergency pre-hospital care.

Chapter 4

E.H.S.C. MANDATE

The Health Emergency Act, R.S. Chapter 162, is the legal basis for the Emergency Health Services Commission. It is a legal entity and an agent of the Provincial Crown, with concomitant rights and duties.

The Commission is the primary provincial responsibility centre for pre-hospital medical care in emergency situations. It is paramount that all persons and agencies recognize and respect that sensitive responsibility in providing a service to the people of this province.

The Commission's powers and authority are set out in Section 5 of the Act. It is quoted hereunder for ready reference.

Power and authority of commission

5. (1) The commission has the power and authority to
   - (a) provide emergency health services in the Province;
   - (b) establish, equip and operate emergency health centres and stations in areas of the Province that the commission considers advisable;
   - (c) assist hospitals, other health institutions and agencies, municipalities and other organizations and persons, to provide emergency health services and to train personnel to provide services, and to enter into agreements or arrangements for that purpose;
   - (d) establish or improve communication systems for emergency health services in the Province;
   - (e) make available the services of medically trained persons on a continuous, continual or temporary basis to those residents of the Province who are not, in the opinion of the commission, adequately served with existing health services;
   - (f) recruit, examine, train, register and license emergency medical assistants;
   - (g) provide ambulance services in the Province; and
   - (h) perform any other function related to emergency health services as the Lieutenant Governor in Council may order.

(2) No person shall, except with the written consent of the commission and on terms it may specify, do anything that the commission is given the power to do under subsection (1).

(3) Subsection (2) does not apply where a person is acting in connection with the provision of industrial first aid in accordance with the requirements of the *Workers Compensation Act* or regulations made under that Act.

1974-30-5; 1985-51-28, effective July 11, 1985 (B.C. Reg. 221/85).

The organization is structured to ensure the provisions of the Act are complied with. It has, since inception, undergone extensive planning and development within this legislated mandate. There are eight "economic regions" in the province, and within those the ambulance service is administered through five "Administrative Centres." They are established as follows:

Centre # 1 - Victoria - Vancouver Island - Region 1
Centre # 2 - Vancouver - Lower Mainland - Region 2
Centre # 3 - Kamloops - Okanagan - Region 3
- Kamloops - Kootenays - Region 4
Centre # 4 - Prince George - North - Region 5
- Prince George - North East - Region 8
Centre # 5 - Terrace - North - Region 6
- Terrace - North West - Region 7

There are three "Dispatch Centres" covering the technical and operational communications for those five administrative regions. They are as follows:

1. Victoria - Region 1 - Vancouver Island, Powell River, Bella Bella and Bella Coola;
2. Vancouver - Region 2 - Lower Mainland and Fraser Valley;
3. Kamloops - Regions 3 through 8.

As will be shown later, and as already pointed out, this vast province does not lend itself to ready interpersonal contact and management. The telephone and the written word are often poor substitutes for communicating in a truly managerial sense. This is even more so under a decentralized structure which the Commission appears to favour through the five administrative centres. In my travels and discussions it was apparent that there was a need for more communication and monitoring, at the local level, and that this might best be achieved through more administrative centres.

I was informed that the E.H.S.C. establishment, as of March 31, 1989, is:

Emergency Medical Assistants II, full- time	529
Emergency Medical Assistants II, part-time	23
Emergency Medical Assistants I, part-time	1438
Industrial First Aid only, part-time	592
Advanced Life Support including unit chiefs	118
Infant Transport Team	16
Dispatchers including Charge Dispatcher	63
Trainers	7
Management and support staff	76
Total:	2862

It would also assist here to explain that the ambulance service provides three levels of service under the "codes" umbrella. In reverse form they are described in the simplest of terms as:

Code 3 - A medical emergency which requires an immediate response. This calls for the attendants to activate the emergency equipment and get to the scene as quickly and safely as possible.

Code 2(A) - A medical emergency which requires a response at the earliest and with the least possible delay. This response status indicates whether the emergency equipment is or is not to be activated, and is dependent on the information and circumstances.

Code 2(B) - A medical non-emergency which requires a response at a designated time. These cases generally involve the transportation of patients between hospitals and homes. The level of care required ought to generally equate with the care given at the sending and receiving hospitals. In some quarters this was also referred to as "Code 1."

There can, of necessity, be an overlapping of code responses at any time. I noted a considerable volume in the Code 2(B) class in large urban centres. So much so, private companies are employed in Victoria and Vancouver to fulfil this need. It should be said, however, that this class of service provides ambulance attendants with a base of training and experience in the care and handling of patients. It also provides a link between ambulance attendants and hospital staff, at a knowledgeable and professional level. Finally, it affords the patient a comfort level in the knowledge he is secure in the hands of these attendants who are consistently trained and equipped. The Code 2(B) requires close examination, particularly in the larger metropolitan areas, but similarly throughout the province.

It is important to make these Code distinctions in order to ensure the reader, and the general public, are aware that E.H.S.C. personnel do much more than attend traumatic occurrences. The current ambulance service is demanding in time and expertise. With that in mind, one must question whether other public or private agencies would suffice, or indeed be willing, to undertake all of these responsibilities under the one emergency pre-hospital care umbrella. In the less populated areas of the province, it would probably be economically unfeasible for private agencies to enter into Code 2(B) arrangements, or even provide the normal emergency ambulance services. The return for providing these services would simply not be there. It must also be kept in mind that the provincial ambulance service has developed an extensive air transportation service, complete with in-flight medical expertise. There is, in other words, considerable overlapping of services which are best effected through a unitary system, albeit the cost is high.

The body which guides the E.H.S.C. in its mandate is comprised of five members appointed by the Lieutenant Governor in Council. Section 2 of the Act provides for this, and is quoted hereunder.

> **Commission**
>
> **2.** (1) The Emergency Health Services Commission is continued.
>
> (2) The commission shall be composed of one or more members appointed by the Lieutenant Governor in Council.
>
> (3) The Lieutenant Governor in Council may
>
> (a) establish the terms and conditions of the members' appointments under subsection (2), and
>
> (b) designate a member of the commission as chairman.
>
> (4) A member of the commission is entitled to his necessary and reasonable travelling and living expenses incurred while exercising his powers or performing his duties.
>
> (5) The minister may appoint a person who, in the event that a member or the chairman of the commission is unable to act from any cause, shall act temporarily in the place of the member or chairman and exercise his powers and perform his duties.
>
> 1985-9-5.

The Chairman is the Deputy Minister of Health. With the exception of one person, others who sit on this body are selected from within the Ministry of Health. Without exploring their qualifications here, it is safe to say they are eminently qualified in the health care field. Membership on the Commission need not be solely from the Ministry; there is no legislated restriction in that regard.

As will be gleaned from what follows, there is much more to this service than pure medical aspects. The ambulance service is one of three major, public emergency services, which services are interdependent and complement one another. Issues which arise in providing one service to members of the public are bound to spill over into the other emergency services. The existence of the G.V.R.D. Agreement is evidence of such. Differences of perceptions, such as those raised in this document, point to this as well. The governing body must, of necessity, experience frustrations in attempting to understand the causes and reach some practical solutions in the management of their operations. It struck me that perhaps the Commission could benefit from having a broader range of representation within it.

Given that these three services, police-fire-ambulance, have a common goal but differing mandates, it would seem to me reasonable for the Commission to draw on the expertise of the police and firefighters in solving mutual problems. One way to achieve that would be to have police and firefighter representation, in a consultative and advisory role alone, join the Section 2 governing body. This could well assist the Chairman in his decision making role. I stress the difference between advisory and decision roles. And I stress the need for consultation and communication, in matters of policy and procedure, between these three important public service agencies.

The police and firefighter representatives need not attend all meetings, but rather attend regularly to maintain the interest of all parties. Subsection 4 would appear to satisfy this concept and need. I suggest this would foster and encourage public confidence in the ambulance service, in the knowledge that the three emergency services are "ad idem" at the highest levels of policy determination. Representation could be drawn from the British Columbia Police Chiefs Association or the Fire Chiefs Association; or indeed, it could come from recently retired police and firefighter ranks. The cost would clearly be minimal, but the benefits potentially high.

The Commission reports annually respecting its progress, so there is no need here to expand further, save to reserve comment as various issues are identified hereafter.

RECOMMENDATIONS

It is therefore RECOMMENDED THAT:

1. The Chairman of the Emergency Health Services Commission consider recommending to the Lieutenant Governor in Council, the appointment of two additional members to the Commission, and that each of these persons be drawn from the police and firefighter services, to attend Commission meetings in an advisory role.

2. The Commission review and consider the creation of more administrative centres, in particular to cover

the northern and eastern reaches of the province, and to ensure local concerns are more personally and directly addressed at the local level.

3. The Commission review its "Code 2(B)" performance level and either:

   (a) increase its equipment and manpower capabilities, and utilize that service as a training enhancement in the service and back-up for emergency services; or

   (b) abandon that service in favour of the private sector, and concentrate singularly on providing emergency services only.

Chapter 5

TRAINING

The mandate to supply training to persons involved in providing pre-hospital care is a responsibility legislated upon the Commission; it is covered in the Act and Regulations. Copies are appended hereto for ready reference in Appendix B.

The Health Emergency Act empowers the Commission to recruit, examine, train, register and license personnel to provide these services. While the Act allows for the Commission to enter into contracts or arrangements to supply these services, training is central to the Commission. All agencies must accept that fact; it is a provincial requirement under the law.

The Regulations set standards respecting the qualifications, examinations, training, registration and licensing of Emergency Medical Assistants. These outline the categories of Emergency Medical Assistants and licence qualifications in accordance with the training standards in the Schedules. The categories are as follows:

(a) E.M.A. I;
(b) E.M.A. II with endorsements;
(c) E.M.A. III with endorsements as follows:
    (i) ALS-I: Advanced Life Support "I"
    (ii) ALS-II: Advanced Life Support "II"
    (iii) ITT: Infant Transport Team
    (iv) Experimental Category as set out in Schedule "I".

The training of Emergency Medical Assistants (E.M.A.) is complex and lengthy, and includes a requirement to maintain a valid licence. When the licence lapses, the E.M.A. must pass re-examination and testing; this procedure is almost as long and complex as the original licencing itself. I heard from some that this process is demanding to the point of exhaustion. Some classed the re-certification program at the J.I. as cruel and unusual punishment; the pressures placed upon those persons was excessive in their minds. The Director of the Academy could perhaps reexamine, not so much the content, as the delivery of this program.

In the public interest, these training schedules should be maintained. Much professional expertise has been expended in the formulation of these training standards; they ought not be treated lightly. The citizen, or visitor to the Province of British Columbia, requiring pre-hospital care benefits from this training in a time of need, and only he can fully respect and appreciate the excellence which this preparation provides.

I heard a great deal respecting the unavailibility of training for attendants. Obviously there is a great deal of pressure on the Academy to train as many as possible in the shortest of time and with limited resources. A quick look at the numbers of attendants in the system underscores that dilemma. However, I believe that if the J.I., in consultation with the Commission, were to communicate a schedule or plan in those respects, it would go a long way towards alleviating the attendants' concerns. There appeared to be general satisfaction with the course content; the problem appeared to be more in the delivery of that service. Reasonable people will accept shortcomings for the most part, if the message is conveyed to them and if they can see a light at the end of the tunnel.

So much for the training provided to Commission employees, the ambulance attendants. Remaining is the question as to what level of training is required by First Responders and those agency personnel under contract to the Commission. Let me deal firstly with the contractors.

In discussions with the seven contractors in the service of pre-hospital care, namely:

(a) Oak Bay
(b) Saanich
(c) Port Alberni
(d) Campbell River
(e) Kitimat
(f) Fort St. John
(g) Nelson;

it was apparent that a higher standard of training than the Industrial First Aid Certificate (I.F.A.) and E.M.A. I level is expected. The W.C.B. standard of one trained Industrial First Aid Certificate for every nineteen members of a fire department was not established with the pre-hospital care system in mind. It was intended and designed to satisfy injuries received at the worksite, and in some municipalities it was a prerequisite for employment. Recognizing this, departments which provided ambulance services, prior to July, 1974, trained their personnel in I.F.A. well above the W.C.B. minimum requirements. Regardless, this falls well below the now legislated provincial standards; I refer here to the various E.M.A. requirements.

It is important to acknowledge then, that if the Commission and a municipality are to sustain a contract to provide emergency pre-hospital health care in the full sense of the expression, the municipal employees must be trained to the same level as the Commission employees. To do less is to render a lesser service to citizens of that municipality. This is not what was contemplated by the Act or its Regulations. It is not, I am sure then, what was contemplated by the Legislature, on behalf of the citizens.

Given that the Commission has the authority and responsibility to set the standards and provide the training to all official emergency pre-hospital care givers, it is incumbent on the contracting municipalities and the Commission to ensure compliance with the law in the interests of their citizens. On the basis that the present contractors are not fully trained as set out in the Regulations, I can only conclude that both parties have fallen short of meeting that statutory requirement. The contracting municipal employees, the firemen, have not been fully trained, examined or licensed, as required. In the best of worlds, this ought to have been done prior to entering into these contracts, and in the least it ought to have been done as soon as possible following the signings thereof. It is fair to say, however, that these departments have the Class 4 driving licences and are staffed with the minimum I.F.A. training. The Commission has also provided training to the E.M.A. I level, but new staff may not have received this. Correctly, the Commission is seeking to provide E.M.A. II level at these locations, accomplished through the Justice Institute extension program, held locally.

Again, we must consider the historical aspects of these emergency services. The fire departments were handling these matters under the St. John Ambulance and

W.C.B. standards prior to 1974. It is unreasonable to expect the Commission and the municipalities to, overnight, provide all E.M.A. levels of service in all parts of the province. It has taken fifteen years to get where they are now, no mean feat in itself. They ought not therefore, be the subject of criticism at this stage of development.

The cold reality remaining at present, however, is that, in the strict interpretation of the Regulations, these seven municipalities are not providing the standards of emergency care enjoyed in other locations of the province; but in fairness, that is also the case in some other municipalities. The conclusion one must draw is that, if these seven municipalities are to continue under contract, it is incumbent on both parties to ensure the attendants are trained to the same levels as provided in other municipalities where the E.H.S.C. is established. The alternative is for the Commission to provide that level of service under its own auspices.

When one examines just how extensive the E.M.A. training is at its various levels, I am sure the Municipal Mayors, Councillors and Clerks will wish to assess the merits of these undertakings. I think primarily of the cost-benefits associated with the training, time away from the workplace, requirements for additional staff, to mention a few. Similarly, from the Commission's mandate and perspective, the feasibility of training at the work site, licensing, associated costs and the like, ought to be the basis for serious review at these contracted locations.

Training under a "First Responder" program shall be addressed in the following chapter.

RECOMMENDATIONS

It is therefore RECOMMENDED THAT:

4. The Justice Institute examine the re-certification program and while not sacrificing content and quality, modify its delivery taking into account actual and realistic local conditions and experiences.

5. The Commission and Justice Institute consult the contracting municipalities to ensure the most effective and economical process for training and licensing of firefighters to the E.M.A. II level.

Chapter 6

THE FIRST RESPONDER

In responding to all levels of emergency pre-hospital cases, the provincial call volume and variety of situations is astounding.

As an example during the 1988 calendar year, the Vancouver area had 36,231 "code 3" responses alone, while in the Victoria area there were 12,336. When one examines this and takes all factors into consideration, it is simply not possible for ambulance service personnel to be everywhere at all times. That is a fact of life, recognized by administrators and practitioners alike, in all disciplines. To the person in difficulty, however, it may appear an eternity until the ambulance arrives. This is understandable and accounts for some complaints that "the ambulance took an hour to get to me," when in reality the indicators are it took 12 minutes. Be that as it may, the initial response in some cases may well be critical, indeed, a matter of life and death. That, too, is acknowledged by all.

Fire department personnel submitted that they are ofttimes in the best position to be the "first responder." Generally speaking, this is true. For many years, fire halls have operated an ambulance service, attending emergencies in the community. They were the first to carry inhalators. The W.C.B. required that they carry a level of Industrial First Aid trained firemen for their own crews, and this expertise also made them highly eligible to provide this service.

Fire halls have tanker and pumper trucks, and many have rescue vans with every conceivable piece of equipment for rescue work. This includes items such as the jaws of life rescue kits, generator and lights, basket stretchers, spinal boards, oxygen, air bags, breathing apparatus, life saving equipment, chain saws, metal saws, hazardous material disposal, fire suits, air chisels, ropes, chains, etc. They are required to suit four firemen on a pumper truck when called to a fire. Their stations are manned 24 hours a day with regular or volunteer firemen. After hours some have a call system to back up those who have left the hall; these are ready for additional fire calls or other emergencies where the community requires their attendance.

Fire halls are strategically located because, historically and currently, the departments planned them with that in mind. It is a credit to those departments and their municipal masters for so doing. They pride themselves on a three minute response time. I refer here primarily to the major municipalities in larger centres.

There were instances of anger and frustration by some fire personnel when they were aware of an ability to respond within that time frame, but were not called and afterwards learned of a perceived delay in response on the part of the ambulance service. On historical, practical and humane grounds, that emotion is not difficult to understand.

What was significant is that both ambulance and fire personnel recognized and accepted this first responder fact. In the absence of more strategically located ambulance stations, more ambulances and more attendants, as weighed against the strategically located fire halls and availability of firemen, it is no wonder the latter is viewed as the more efficient first responder. The general rule that seemed to apply was: the closest to the scene ought to be the first to respond and attend. Ofttimes the police would be first on the scene, but in the same breath, the police were neither equipped nor adequately trained to respond in a medic fashion. Thus there evolved the three way frustration: police, fire and ambulance. Regardless, someone in an official capacity does respond immediately, and this provides some comfort to the person in distress. It was sometimes characterized as simply a "hand-holding" exercise.

Aside from training, the major problem that evolved out of these scenarios centred on communicating to the closest agency. That issue shall be dealt with more specifically under "Communications". For the moment, it is important to confirm that when a call is received by any one of the three agencies, the response time is minimized by immediate dispatch of the closest vehicle and personnel, with concurrent advice to the agency having primary responsibility to attend.

Those fire departments which practise the First Responder system, respond to the emergency with rescue vehicles or pumper trucks. Their response time is usually excellent and they exercise patient care until the arrival of the E.H.S. ambulance crew. They turn over the patient and information obtained, departing the scene when their services are no longer required. Where firemen operate the ambulance under contract, the patient is transported to hospital by them.

Unfortunately I heard strikingly damaging evidence of situations in which there was a perceived "competition" to reach the scene first. Instances were related where fire trucks appeared to:

(a) "run the ambulance off the road;"
(b) "travel parallel to each other from a previously tandem run, in order to block an ambulance from passing;"
(c) "blocking access to the scene or patient;"
(d) "leaving the access door to a high-rise locked and proceeding to the apartment with the manager, thus precluding access by ambulance attendants."

These are devastating accounts, particularly to the person in distress, and particularly if he were to become aware of that.

If, indeed, there is any "competition" between these two public service agencies, it ought never be at the expense of the public safety, or at the risk of jeopardizing the care and well-being of the victim. There were no such accusations levelled at the police. Ambulance attendants had nothing but the highest praise for police officers in the first responder and assistance role. Ambulance attendants were simultaneously conscious of these situations being isolated. They acknowledged that the majority of firemen were helpful at the scene. But it is this type of incident which serves no good and which, by the time it reaches the ears of other attendants and firemen, creates distrust and animosity between the two agencies.

Having noted this, one should not get a totally negative impression as to the relationship between the two services. There is, on the contrary, a very positive "on the street" relationship between police, fire and ambulance personnel. That, I found to be the consensus. The resolve lies not so much through a complaint mechanism and disciplinary process, although they do have their place on occasion; rather, I believe the answer lies in understanding of each other's responsibilities through education and communication, infused throughout with common sense. Experience tells us that, in situations of high excitement and fever, where the adrenalin runs fast, the normal rational process can diminish to irrational levels. This should not be the case amongst professionals, particularly when a fellow human in need must be the sole object of attention.

I heard a great deal regarding the absolute necessity to respond to emergencies within a three minute window. It would perhaps do us well to reflect on this for a moment.

The first responder principle alluded to earlier is simply the closest emergency vehicle responding without delay and in the safest, most expedient manner. To race to a scene on the basis it ought to be within three minutes is questionable. The public appreciates the difficulties in these scenarios; and I think common sense would have emergency responses be guided by the dictates of reason, not a pre-conceived statistic. All first responders should be guided by the emergency, and all the conditions involved in reaching it. Statistics ought to be examined and judged after the fact; they should not determine the fact.

Fire departments pride themselves in this three minute response frame; and this for a variety of reasons.

I was advised that, with the rising population in the lower mainland, this response time will become five minutes. So it's relative. And rightly so; it relates to many conditions, some of them beyond the control of the responder. In remote areas the three minutes can expand to hours. Indeed, it is relative.

I suggest it is perhaps time this three minute syndrome were laid to rest. With an efficient first responder system in place, well defined and generally understood, ambulances could attend scenes safely and within a reasonable time frame. It makes no sense for ambulance attendants to arrive at a scene, adrenalin pumping from a high speed and dangerous trip, to find the only heart beat they hear is their own. Some patients are going to die in one minute responses. Others have a chance for survival as a result of immediate dispatches by the communications personnel. Assistance is also available on the telephone. The first responder is available. Those avenues all complement the attendant in reaching his objective to render assistance, when he arrives in a sensible fashion.

The First Responder system should be examined in conjunction with a "layered response system." The key to such an approach is the simultaneous involvement of police and/or fire in responding to an emergency situation. The details of that would have to be determined in concert with those agencies, and be the subject of specific protocols.

This approach may also curtail the perceived "competition" between agencies. I am advised that only 30% of all calls are Code 3, and that upon arrival at the scene, this is usually downgraded by 5%. The three minute syndrome requires revisiting, vis-a-vis the "First Responder" and "Layered Response" approaches to the problem.

It should be noted that the R.C.M. Police has recognized and is pursuing a Police Officers' First Responder (Medic) System. I learned this is also being examined by other municipal police forces in the province. Given the correlation between the three emergency services in this province, and given the merits of the proposed program at the Justice Institute, it would do well for all police forces in British Columbia to buy into the J.I. program, if for no other reason than uniformity and consistency of purpose, as discussed in Chapter 5.

The First Responder concept appears to receive the general approbation of all three emergency services - police, fire and ambulance. At the moment, police and fire personnel provide this service to varying degrees in the wake of ambulance attendants' inability to be "Johnny on the Spot."

There are no provisions in the Regulations which address First Responder training. This is covered obtusely by way of the two first aid levels - St. John Ambulance and Workers' Compensation. This was historically adequate; but, then, so was the "scoop and run" principle. All three emergency services advise this is no longer adequate. The legislation implies it is insufficient. The general populace have become accustomed to a higher standard, so now they find it deficient. Clearly, British Columbia has reached the E.M.A. level, and it ought not reverse itself at this period of historical development.

The question then arises: how can First Responders provide an appropriate service, a standard, which approximates the E.M.A. I level? In the face of the Commission's inability to meet the First Responder test in many instances, the answer lies in training the other two emergency bodies. The Commission has that responsibility within its mandate.

It should be pointed out here that, in referring to police and firefighters, there is no legal requirement on those agencies to respond to emergency health duties. I make that observation because from the other side of my mouth I am saying they should be trained and respond. This is a moral obligation, a Good Samaritan law, so to speak. It is a public service historically and humanely expected of them. And while perhaps stepping out of line within my mandate in this report, I nevertheless urge municipal authorities to acknowledge and encourage participation by their police and fire departments in the rescue and first responder programs. Professional training and adequate equipment is an absolute necessity, if total success is a considered goal. The three agencies must work in concert towards that objective, ensuring operating protocols are in place.

In course content, the developer must be cognizant of those aspects in which policemen and firemen are already trained, and which currently form a part of the E.M.A. I and II training. The driving of emergency vehicles, requiring a Class IV licence, comes to mind. The existence of St. John and W.C.B. first aid is another. Most police and fire officials are already so qualified. Course design should not bore the recipients by way of repetition; nor should the materials be superfluous or irrelevant. First Responder training should concentrate on two principal goals: immediate medical aid, and pre-hospital preparation which would assist both the secondary responder (E.M.A.) and the medical staff at the emergency reception centre.

The Justice Institute of British Columbia already houses the three emergency forces, with existing training modules. It is eminently qualified and equipped to provide this support service.

In light of the extensive and specialized requirements contained in the E.M.A. programs, and in order to distinguish between the two programs, I would suggest the First Responder program be identified and entitled separately from the E.M.A. title. The E.M.A. classification ought to be restricted to those personnel, employed by the Commission as ambulance attendants, who have completed the particular requirements envisaged by the Regulations. Police and fire personnel, attending in a First Responder role, ought to be identified singularly and in accord with the unique course they qualify for. The simplest of identifiers would be "Emergency First Responder" (E.F.R.) It was an expression used by both fire and ambulance personnel throughout these discussions, and perhaps thus best known to all. Another might be "Medic I" and "Medic II", which seemed to have an historic connotation. The title selected is best left to those who are better qualified to cogitate on such matters; so long as the selection is one with meaning and common acceptance.

I found it encouraging to discover, at the time of writing, that the Directors of both the E.H.S. and Fire Academies, at the Justice Institute, combined forces in preparing a "Discussion Paper" on this very topic. It is current, being dated March 21, 1989. It is entitled "The Professional First Responder" and addresses the very issues cited in this chapter. Clearly, this indicates to me that both trainers in the two professions recognize a need and are taking steps to fill the gap. It was also encouraging, in speaking with the Fire Commissioner for the province, to learn his agency planned to provide additional funds to the Fire Academy for these purposes. This joint effort is acknowledged within the E.H.S.C., and judging from its 1988 Annual Report, appears to have received the Commission's blessing as well.

This is clearly a good start in the right direction. It also indicates that at the Justice Institute there is a meeting of the minds on the topic. It should be encouraged and pursued. Of interest is the suggested title for this training course: "The Professional First Responder" (P.F.R.), which complements the E.M.A.'s in the Commission. A copy of that paper is attached as Appendix C.

As the training for this ought to be undertaken at the Justice Institute, as it is essentially a provincial public service to persons in need of emergent medical attention, and it is intended to assist the Commission in its mandate, it would seem appropriate that the costs thereof be underwritten entirely by the Commission. I refer here to the training costs only, including travel and living expenses. The wages and other expenses normally paid to municipal employees ought to be borne by the respective municipalities. That, clearly defined, would assist the municipalities in determining the merits of sending candidates and preclude the perennial arguments surrounding which level of government pays for what, who pays the lion's share, and so on. It would also afford the less wealthy municipalities an equal opportunity to share a level of pre-hospital care similar to the more wealthy. It would reduce the bookkeeping as well. In the final analysis, the provincial taxpayer is going to pay; and this same taxpayer is going to receive the same level of care regardless in what part of the province he calls for help. In real terms, there is cost sharing here. Granted, it will call for an infusion of funds. I should add here that the "First Responder" program could also be delivered locally as is done in the E.M.A. I and II programs.

There is also a spin-off to this type of program. The more police and fire personnel trained, the more benefits will accrue to the communities in which they live and which they serve. This type of training will spill over to not only within their personal employment, but also to their families, neighbours and the general public. Accidents happen to anyone, anywhere, anytime. The more people trained to respond, the quicker and more effective the response. It makes good sense from a pragmatic viewpoint.

RECOMMENDATIONS

It is therefore RECOMMENDED THAT:

6. Police and Fire personnel continue to perform a First Responder role in emergency pre-hospital care cases.

7. The Commission develop specific operational protocols between police, fire and ambulance services, with particular attention to dispatching to the scene; and that regional administrators thereafter consult and communicate with the local authorities to ensure

understanding and compliance with those two authorities, police and fire.

8. The policy clearly enunciate that, if an ambulance cannot respond immediately and within a reasonable time frame, as the First Responder, the dispatcher ensure a police and/or fire First Response, immediately.

9. The Commission examine its statistical data respecting response times, using that data as an informational guide for resource purposes as well as an instructional guide for attendants.

10. The Commission, in concert with the Justice Institute, develop a First Responder course (P.F.R. - E.F.R. - Medic I/II) for police and firefighters.

11. The training, travel and living expenses for attendees be underwritten by the Commission.

12. The wages of municipal employees attending this course be underwritten by the respective municipalities.

13. Consideration be given to conducting these courses, or portions thereof, locally, in order to reduce costs and inconveniences to municipal employees.

14. Consideration be given to training instructors in the First Responder system, at the local level, on the principle of "each one, teach one" to encourage wider community participation and support.

Chapter 7

CONTRACTING WITH MUNICIPALITIES

Alluded to earlier, in 1973-74, the Fire Chiefs Association of British Columbia declined the offer to provide a province-wide ambulance service. In spite of that position, a number of chiefs who had been providing this service to their communities did not concur, resulting in a continuance in those municipalities. In my discussions with some mayors and senior municipal officials, there appeared to be an overriding desire to provide the best service, by whichever agency, for their constituents. They were very supportive of their departments, stating they believed their particular firefighters were doing a good job in providing an ambulance service.

Individual contractual arrangements were entered into, pursuant to Section 5 (1)(c) of the Health Emergency Act. With the exception of Oak Bay, which terminates on December 31, 1992, the remaining six (6) contracts end on March 31, 1992. There is, in addition, a 180 day termination clause available to either party to these contracts. They are located at:

Oak Bay
Saanich
Port Alberni
Campbell River
Nelson
Kitimat
Fort St. John.

There are similarities amongst Campbell River, Port Alberni, Nelson, Kitimat and Fort St. John. They are distinct communities, separated from other centres by distance and economies. They would fall into category (b) - less major municipally-organized districts. It should be recognized, however, that there are any number of other similar municipalities throughout the province, where the Commission has established stations and personnel. I think of locations like Duncan, Dawson Creek, Terrace, Grand Forks. These are municipalities in proximity to the contracted locations with more or less the same geophysical conditions. The simple question one would expect is: why have one system in place there, and another system in place next door? Particularly so when one views emergency services from the very broad provincial base. Is one system more efficient and effective than the other? If yes, why? Is one more cost effective from the taxpayers' perspective? Are there differing standards of pre-hospital care between these locations? Are the firefighters trained to the same level as ambulance attendants? Does local knowledge and understanding supersede the provincial picture? Is it better to have a mix - fire and ambulance - or a singular "one man, one job" service?

Oak Bay and Saanich fall into a different category. They are situated in an area more akin to the (a) class - major urban/regional districts. Here we have two ambulances provided by the Commission and staffed by firemen in a geophysical area where there are no less than 20 ambulances and 56 emergency health personnel. Between these two municipalities lies the City of Victoria which has no ambulance at its fire halls, and sees no need for contracting in those respects. The general population in that fairly large urban setting, Greater Victoria, would be expected to question that. However, I would suspect they just want a response when the need arises; they draw no boundaries or stances when in a crisis situation.

It must be recognized here that the Saanich fire department, historically again, provided perhaps the best ambulance service in the province. They went to great lengths to train and equip their firefighters in pre-hospital emergency care. And they still have some personnel who fall into that category. It is no wonder some of the local Saanich fire personnel's interest remains so high and intense. The argument is posed they are not only the best responders, they are also well trained to boot. But, as in the six other municipalities, the question remains: is this arrangement more efficient and effective, given all the considerations?

In addition to those formalized contracts with the seven municipalities, there exists informal, unwritten agreements with some other organized and unorganized bodies. I refer to the likes of View Royal and Central Saanich where the Commission has provided those fire departments with an ambulance, and the department has assumed the responsibility to provide the emergency service. In these instances, while the Fire Chief and his deputy may be full time employees, the remainder are volunteers on the department. While this may appear to be the lowest level rung of the service ladder, the serious devotion of those personnel to the task at hand is astounding and commendable. Granted the equipment is provided and remuneration is involved, they nevertheless reside alongside the larger urban municipalities of Victoria and Saanich. Indeed, a mile away from the View Royal fire hall are two provincial ambulances stationed at the General Hospital on Helmcken Road. The same questions arise as applied to Saanich and Oak Bay, given the existing provincial ambulance service in that larger [category (a)] urban setting.

Langford Fire Department permits the B.C. Ambulance Service to house its ambulance at their fire hall, but the staffing is by way of part-timers from the Ambulance Service. Holberg, at the other end of the Island, is provided an ambulance but staffs it with members of the Fire Department. There is no written contract in either of these cases. Contracts are utilized only where the Fire Department utilizes its full-time staff.

During my meetings with the contractors it was evident that they had discussed their contracts among themselves. Reference was made to the negotiations as a "divide and conquer" tactic on the part of E.H.S. In examining the seven contracts I found they are not uniform, which may lead the contractors to that conclusion. I also sensed, in the case of some contractors, a very strong loyalty to their departments and municipalities. It was not unlike the stance, to which I allude in Chapter 12, taken by the Union and the Firefighters' Association. It was strong indeed.

At the conclusion of this chapter I have assembled a chart which indicates some differences. While each contract is recognized as separate and distinct, as between the parties, I nevertheless asked why when the contractor is providing essentially the same service, the same equipment, and the same manpower.

One gleans from this that there are a variety of arrangements ranging from total control and commitment at some locations, to as and when needed by volunteer firefighters at other locations. These variations lead to disputes and conflicting positions between the Commission and some of the departments.

For instance, a department might utilize the ambulance in its routine fire inspections. E.H.S.C. would object, stating it should not be, and that the ambulance was thus unavailable for emergency medical calls. The department might argue it was more readily available, perhaps even closer to the scene. In the same vein, the department might take the ambulance to a fire scene, arguing it could be required at that point. E.H.S.C. would counter by stating if the ambulance were needed in a medical emergency, the firefighters could not be readily prepared, dressed and cleansed, to respond to that situation. Ambulance personnel argued that firefighters were primarily concerned with the fire; the fire chiefs stated their concerns were life-saving first and property protection second.

Fire chiefs stated they would be called to respond only when an ambulance crew was unavailable. The first call from dispatch would go to E.H.S.C. personnel as a cost saving measure, regardless of location and response time. Some departments recorded these response times so indicating. A unit chief stated the ambulance at one fire hall is seldom called, perhaps six times a year, and when he went to inspect it, the battery was dead and the rear of vehicle contained firefighting equipment.

Clearly, there were differing views on the best methods for handling calls. Some fire chiefs expressed strong positions respecting the operational management of dispatch centres vis-a-vis the quickest and least costly response. They argued neighbouring units were not staffed "around the clock", with the attendants having to get out of bed, drive to the ambulance station and then leave for the scene. All were of the view their departments were more responsive and cost efficient.

What I did find significant was the fact that the majority would accept a separate, distinct ambulance service, if that service were as responsive, efficient and cost effective as their department. While they were concerned with the impact the establishment of a station in their municipality would have on firefighters' jobs, the majority would bow to E.H.S.C. providing a first class ambulance service to their community. They recognized the division of labour between the three emergency services. But until such time, they were of the firm belief they should maintain the service to their communities, provided they were afforded the appropriate level of training and were compensated fairly and justly.

It was also revealing to me that, in my discussions with some firefighters, they indicated they joined the fire department to be ambulance attendants. They enjoyed performing that task because it gave them a sense of reward in seeing and being thanked by the person they assisted. They felt a strong sense of community commitment. That relationship was evident in my discussions with hospital staff and other community members as well.

What struck me most forcefully was the local community identification throughout. I believe this to contribute largely to the support firefighters receive when acting as ambulance attendants. As an example, when I discussed with an R.C.M.P. officer the possible impact of establishing an ambulance unit in one of these contract municipalities, his first response was: "Would they be hiring locally?" I suggest the same spirit and philosophy does not apply in large metropolitan areas like Vancouver. And that is understandable.

But all this must be weighed against the broad mandate of the E.H.S.C. Local community wishes must be respected against the backdrop of a provincial emergency health care service. There are arguments for fire departments retaining and maintaining this arrangement. If E.H.S.C. is going to establish stations at these locations it must assess and take into account those local nuances. It would do well to assume the same commitments as the police and firefighters. And before it takes on those responsibilities, the community must be assured of a complete service, response-wise, round the clock, efficient and effective. I believe that ought to be the goal of the Commission, but only through strategic planning and in consultation with those local authorities.

I also believe that if the Commission were to improve and enhance its existing structures, those locations under its immediate management, proving to all that the provincial service is the way to go in the future, that the contracting municipalities will opt for the service because it is as responsive and as efficient. There exist divisions between the three emergency services, and they are working well in some areas; the Commission would do well to capitalize on that. At this stage it would also benefit from examining why it is not doing as well at other locations, improving as necessary and adjusting, or fine tuning, as resources permit. After fifteen years of relatively hectic expansion and development, perhaps it is time for a breather, realignment and a statement of future goals. The recommendations following are submitted with all of the above in mind.

RECOMMENDATIONS

It is therefore RECOMMENDED THAT:

15. The Commission, in the case of Greater Victoria Regional District, adopt the same structure and system in providing ambulance services, as exists in the Greater Vancouver Regional District.

16. The Commission consult with the municipal authorities in Oak Bay and Saanich, with a view to terminating those respective contracts at a mutually convenient time, but not later than the life of the existing contracts, and thereafter provide a provincial service to those communities commensurate with their needs, from a Greater Victoria or capital region perspective.

17. The Commission examine the existing arrangements at View Royal and Central Saanich, with a view to doing likewise at those locations, and providing one centralized service in the greater Victoria region.

18. The Fire Departments at Oak Bay, Saanich, View Royal and Central Saanich adopt the First Responder method to medical emergencies in their municipalities, as recommended in Chapter 6.

19. The existing contracts at Port Alberni, Campbell River, Kitimat, Fort St. John and Nelson, remain and continue in force until such time as the Commission can establish permanent, full time units at those locations; and that the Commission and respective municipalities consult and be mutually assured that the service to be provided will be commensurate with, or exceed, the service currently provided.

20. When establishing units in the above five municipalities, consideration be given to hiring medically trained firefighters within the ambulance service at those locations.

21. Those five municipalities thereafter participate in the First Responder program, and that they have the first opportunity to receive, at no cost to the municipalities, emergency vehicles disposed of by the Commission, in a dual "rescue-first responder" role.

22. The Commission undertake to provide emergency medical training and licensing, to the E.M.A. II level, to members of the above five contracting municipalities, for the life of these contracts, in order to ensure compliance with the Act and Regulations, and at no cost to the municipalities as recommended in Chapter 5.

23. The Commission consider donating emergency vehicles which are no longer needed by the Commission, and are slated for disposal by the Commission, to municipalities which could utilize them most effectively in a dual "rescue-first responder" role.

CONTRACT AND SCHEDULE "3"	SEVEN CONTRACTORS						
	NELSON	FORT ST.JOHN	KITIMAT	CAMPBELL RIVER	PORT ALBERNI	SAANICH	OAK BAY
Training Clause	Yes	Yes	Yes	Yes	Yes	Yes	No
Reimbursement for I.F.A. Registration	Yes	Yes	Yes	Yes	Yes	Yes	No
PAYMENT OF CONTRACT - $200.00 per call - 3 hrs or less - $ 60.00 per Hr - over 3 hrs - calculated in 1/2 Hr increments	Yes	Yes	No	Yes	Yes	No	No
PAYMENT OF CONTRACT - Flat rate of $75,000 for 1st 375 calls - Over 375 calls, $200.00 per call 3 Hrs or less - $60.00 per Hr over 3 Hrs calculated in 1/2 Hr increments	No	No	Yes	No	No	No	No
PAYMENT OF CONTRACT - Flat rate of $84,000.00 for 1st 375 calls - Over 375 calls, $200 per call under 3 Hrs - Over 3 Hrs, $60.00 per Hr calculated in 1/2 Hrs increments	No	No	No	No	No	Yes	No
PAYMENT OF CONTRACT - $60.00 per call (minimum 4 Hrs) - Over 4 Hour call calculated in 15 minute increments. No minimum number of calls in 4 Hr, block overage commences 15 min increments	No	No	No	No	No	No	Yes

Chapter 8

AMBULANCE STATIONS

In considering the operational efficiency of this emergency service, an important factor is the location of ambulance stations. This applies generally, throughout the province, and is not limited to the large urban areas alone. The administration in the Commission must find this to be vexatious. Submissions and determinations in these matters require input from the British Columbia Building Corporation (B.C.B.C.) It must also deal with various levels of government. I appreciate the existence of some standards at the moment, and submit the following in the hope it shall complement those endeavours.

There are many factors to consider in the selection of a proper site. The primary consideration throughout has to be ready access to the patient. All other issues become secondary to that. I discussed in Chapter 6 the issue of response time. This is significant when weighing a location site.

I heard over and over how fire stations are ideally located to meet a three minute response target in urban areas. I also heard where ambulance stations, if located at the fire halls, would best provide this response time. I concluded that some ambulances would, indeed, be ideally located at fire halls. But I also heard that these presently existing services are incompatible, for a variety of reasons, and that such a marriage of convenience would only end in divorce in time.

Be that as it may, the Commission would do well in its long range planning to take a leaf out of the fireman's manual when deciding upon ambulance sites. In choosing a location, fire departments commence with a detailed study. Indeed, they have a complete manual for this alone. It includes an examination of population densities, planned zoning, industrial development, traffic patterns and future road expansion, to name a few. This is perhaps less difficult for the fire departments; they are municipally managed and controlled, with easy access to municipal information.

I comment on this because I learned how difficult it was for the Commission and B.C.B.C. to obtain the necessary zoning approval for ambulance stations at some locations. In one instance, it became necessary to locate one city block outside the municipality, inside another municipality, but serving the first municipality. In another instance the location had to be between two municipalities, for the same reasons. In such cases, how can citizens expect early responses if the stations are not ideally situated? As always, there are reasons for these types of difficulties; but in the interests of the person in need, surely there can be a meeting of the minds. The problems are perhaps resolvable only at the higher echelons in the political arenas.

In visiting several of these stations I found them generally suitable to the comforts of the employees. Some were better than others, as might be expected. The attendants had differing opinions as to the suitability. I did not find this unusual, for personal tastes differ; it is not possible to suit every employee absolutely, although one station visited expressed complete satisfaction. Some stations are housed at hospitals. It is an ideal location for A.L.S. attendants. Consideration should be afforded the needs and comforts of employees at those sites. One instance complained of a small cramped room with washroom facilities some considerable distance away. These situations are not easily resolvable, given the varying jurisdictions and authorities. Nevertheless this is recorded for posterity and possible future planning.

While financial resources play a significant role in these matters, experience tells us that input from the user can serve a useful purpose in many instances. Consultation and communication. One thing is for certain. Strategic planning in the building of more stations, properly located and reasonably equipped, is a critical consideration for the Commission to address. This they appear to be doing. It will take time and a great deal of patience and understanding. And it takes money.

With an adequate and efficient First Responder system in place, it is unnecessary to have as many ambulance stations as fire halls. Nevertheless, there is a need for strategically located ambulance stations, not unlike the needs in police services. Each locale must be studied, akin to police and fire examinations, and determined on their own merits.

RECOMMENDATIONS

It is therefore RECOMMENDED THAT:

24. The Commission, in consultation with B.C.B.C, develop a manual to serve as a construction guide for ambulance stations, and which would include site selection data for use in consultation with municipal planners.

25. The Commission develop a strategic plan, encompassing up to 20 years, in which the establishment of ambulance stations is predictable and foreseeable, and for which adequate funding and manpower requirements can be assured.

Chapter 9

COMMUNICATIONS - TECHNICAL

A great deal of personal energies and financial expenditures have gone into providing a technical communications network for the Ambulance Service in British Columbia. Much remains to be done and is therefore being planned by the Commission. It is a difficult, and at times frustrating, field of endeavour.

Three main communication centres have been established to provide a provincial service. They are located at the Regional Headquarters in Victoria, Vancouver and Kamloops. Plans should be formulated to expand this so that the systems may become more efficient. Use of satellites may be expanded through B.C. Tel. The Commission's plans are set out in detail in the 1988 Annual Report. This use of satellite channels will afford unhampered operational coverage without the expense or reliance on line control circuits. It will also provide unlimited address capabilities via 911. This takes planning, time and money; it is not an overnight venture. It is gratifying and comforting to learn this is at least in the discussion stages.

The communications network, by its very nature, is complex. It requires constant supervision and scrutiny. The 911 telephone system is in place in some areas, hooking up all three emergency services. This too is beneficial.

This 911 call can automatically register the name and address of the caller onto the screen of the dispatcher at one of these locations. In any situation, but more particularly in an emergent case, this assists in providing a speedy response. The dispatcher at least knows the location of the call. But in medical emergencies the dispatcher must also have additional information if he is to effect a proper level of response. A first responder may be adequate, followed by an E.M.A. response. It may also be an A.L.S. call, or an infant in need. The screen is helpful, but the dispatcher requires more. The caller doesn't know he is speaking with someone who may be hundreds of miles away.

This gives rise to problems in some instances. It is not uncommon for the caller to be excited and incoherent. Invariably the description passed on to the dispatcher is inaccurate, but at least there is an address on the screen. Frustrations on the part of the caller, when asked for details, are not unexpected. So with all the best technical hardware the Commission can muster, there remains the all important human factors in this communication network. In the absence of a well trained dispatcher, or communicator, the system will fail in responding adequately.

There can be systems breakdowns as well. I was advised of such a case on Mother's Day of this year. Because of the heavy load on the telephone circuits, telephone communications in the northern part of the province were jammed for four hours. Persons attempting to call the emergency numbers were met with the ever familiar recording: "All our lines are busy. Please try your call again." One can quite imagine the frustration, anger, and indeed fear in trying to place an emergency call. The Commission and B.C. Tel had not foreseen this, but now have dedicated lines in place to prevent a recurrence. These are technical problems, but impact seriously on humans.

Local knowledge is an important factor for dispatchers as well. Two cases were brought to my attention. A simple request to attend a motor vehicle accident "on the second double "S" curve on the hump" was one. There is no formal address, but even the children in that locale know where "the hump" is. The second was a "heart attack at 1896 Island Highway." The all important local question is: north or south? Local knowledge dictates a great deal; sometimes it can mean a matter of life or death. These are problems which dispatchers and local attendants must deal with constantly.

I heard of a practice of "stacking calls" received from some remote areas of the province. In one case some distance from the dispatch centre, the fire department dispatcher watched a call for an ambulance go through his system (red light), and watched in anticipation of being called for some twelve minutes. In frustration he called the dispatch centre to be then advised to respond. Responses from dispatch ought not be stacked, but relayed immediately to the local attendant or responder. These cases are obviously, I would think, exceptions to the rule. But they deserve constant supervision and vigilance. The first responder in question was faced with "why did it take so long for you to come?" He advised the caller that he responded immediately, albeit some eleven/twelve minutes after the call was placed. The caller thought he was calling the local authority, after all it was a local number. Little did he know the call was received many miles distant. The technical system did not fail him, the human system did.

When a call is received in the dispatch centre, the message should be transmitted without delay. Local expertise and knowledge should thereafter prevail. It is appreciated the dispatcher must obtain additional information from the caller respecting medical circumstances and "tombstone data." These are judgment calls which vary with the circumstances, of course. But much of this information will be obtained at the scene by the local responder. The dispatcher's first response ought to be to dispatch, with the information to follow. Patients should not be buried for want of information.

If there was one area which drew the most consistent criticism in my travels, it was with the dispatch system. One got a sense that in some smaller towns and cities it would work better if the local citizenry could call the local station, or detachment, or fire hall directly. That person would be conversing with a local person who knew the local layout "like the back of his hand." It was the concensus that the dispatchers had no idea of locations or distances involved. One contract department stated it tried to implement locally but this was rejected by the Commission for statistical, operational and financial control reasons. Other irritants are related herein, but lack of local knowledge and dispatchers seeking "too much information from the caller" appeared to be the greatest deterrents to responding. Perhaps if the Commission were to discuss these issues with the local users at the local level, improvements would follow. In the interim, it is a clearly identifiable sore spot at the local level.

While the communications network is deemed absolutely essential in emergency services, there are two interdependent parts therein. One is technical, the other human. Neither without its problems, the Commission must ensure a constant watch over both at all times.

RECOMMENDATIONS

It is therefore RECOMMENDED THAT:

26. The Commission continue strategic planning in the latest technology by ensuring adequate funds are available and the expertise to deliver the product is so encouraged.

27. The Commission, through its administrators, ensure adequate supervision and control in dispatch centres to assure immediate responses, a gaining of local knowledge and conditions, the first responder system is complied with, and the stacking of calls is discouraged to the lowest minimum.

Chapter 10

E.H.S.C. EMPLOYMENT - STAFFING

Since its birth in 1974, the Ambulance Service in British Columbia has grown and developed into a sizeable organization. From a zero base, in terms of person power, facilities and equipment, it now counts 733 full time employees (excluding management and support) and 2124 part time and volunteers. When one considers the relatively short time frame here, and considering the training required to reach the legislated levels of expertise, the development can only be classed as phenomenal. It obviously required a great deal of ingenuity, goodwill and resource support in all quarters.

It is also evident that, in those intervening years, the philosophical bent and desire to assist fellow humans in distress was a major motivator in this success story. In speaking with citizens who have availed themselves of the service, and in communications with various police and fire personnel, there is clear appreciation and support for the current ambulance service. Not unexpectedly, the system is not perfect; but then, what system is when humans are in control and when humans judge others from external vantage points? There are expressions of "not enough"; not enough personnel, not enough ambulances; not enough stations; and so on. But surely those observations signal support and encouragement in view of the absence of comments like: "it was better before," "we don't need and don't want the service." The vast majority favour the first and reject the second stance.

The three emergency services, and more importantly the general public, voice unanimous concurrence. The police are clearly supportive. We heard from firemen, at all levels, that the service is necessary. From the police and fire services, I heard: "it was good to see the ambulance arrive," and from ambulance attendants: "it was good to have the police and the firemen there." It is abundantly clear that all three are interdependent, relying on the other to exercise the particular skills of each trade. It is this type of private and public observation which permits and inculcates public confidence in all three systems.

The basic tenet for ensuring this sense lies with the ambulance personnel on those front lines. They must be adequately trained and equipped to deal with the moment. They must recognize and respect the peculiar responsibilities which attach each function. And, most importantly, they must possess and display a sense and attitude which is most professional and which instructs the public that they indeed can have confidence in the system.

The Commission has grown from infancy as indicated. It continues to expand as time and resources allow. If it is to succeed in the future, it must pay particular attention to the most significant resource it has; its employees. These persons actually save lives, and they actually save money. The difference between responding quickly and effectively can mean the difference between a seriously injured person dying, spending the rest of his life in hospital, or returning to normalcy as a productive member of society. It is a test of man's humanity or society's inhumanity. In either sense, there is a considerable financial outlay. If the system is to succeed, it should be examined from society's needs in the initial instance, and from the financial burden in the final setting.

I found and concluded the one person station, for instance, to be untenable. The conscientious dedication of these one person operations appeared to exhibit itself through signs of stress and hypertension. There appeared little relief from, not only responding to calls, but also the anticipation at all hours and all days. The day of the one man police department, regardless of size and location, has long since passed. And I say this in spite of the volunteers or part-timers who complement the one person; volunteers, who, I might suggest, are the unsung heroes of the system. There are instances of one person stations manned by volunteers. That should not be, in my opinion and the opinion of others. The one person station deserves examination from both a humane and work ethic perspective, not to mention the operational side.

Speaking of the part-timers or volunteers, again the issue of remuneration arises. The primary motivators appeared to be community spirit and a high level of job interest; they are paid according to call outs. During quiet times they spend days or nights at the station with no remuneration. Granted this is not an easy resolve, and one would not wish to debase that motivation through infusions of money, I nevertheless believe it worthy of consultation. And while the almightly dollar was never known to solve all problems, society does seem to respect it as a form of recognition and equity.

We are again drawn to the myriad of geophysical considerations. One cannot apply the same staffing standards to all locations throughout the province. The perception of personnel in the lower mainland might be that the outlying areas "are a touch." To the outposts, the mainland and Victoria are "fat cats." But when the call volume is examined, one quickly disabuses himself of such a notion. The method for determining what is actually best, is an examination of each location, through consultation and communication. Because of the obvious constraints, I was unable to do this. It would be commendable, however, if that were done strategically in the interests of the personnel and the service.

Stress is a significant factor affecting personnel. While some of this can be attributed to internal issues, the very nature of emergency services, be that police, fire or ambulance, creates a toehold on personnel. Ambulance attendants are trained to dedicate their energies on the victim who is traumatized. I heard from attendants who said that is their sole concern; they are oblivious of the environment surrounding them. Some of the more serious incidents, where the trauma level is high, must by their very nature, impact the psychological well being of attendants and their families. I am not certain the public is aware of that. Granted, it is part of the attendants' territory. But not for granted is the manner in which this ought to be visited by the staff and the administration.

It is my belief that, in addition to some form of stress management training as a part of the basic and advanced modules, internal causes such as hours and conditions of work, manpower planning and the likes, deserve close examination. Communication and consultation at and between all levels of the administration, would well serve the organization in its growth and development.

During these travels two other points were raised by some personnel. The first concerned an apparent lack of consideration in hiring local part-timers and volunteers when filling vacancies. Province-wide competitions seemed to take precedence in the eyes of these attendants. Given that all other qualifications are present, these felt they should be given a preference. Another point made concerned "name tags." Some felt that regular employees should wear name tags with the training level indicated thereon. Volunteers should likewise be identified as such, with the level of training they had achieved.

Some of these matters are, by their very nature, complex. There are no simple, one-way solutions. But I am confident that, given the quality and interest of all these employees, and perhaps given some financial infusion to achieve these objectives, the public's most important resource in emergency pre-hospital care will ensure an even more effective, efficient service to the general public.

RECOMMENDATIONS

It is therefore RECOMMENDED THAT:

28. The Commission review all "one person stations" by consulting those unit chiefs, with a view to increasing support and reducing the stress and tension.

29. The Commission review the lot of part-timers and volunteers, by consulting with them respecting their frustrations and expectations.

30. The Commission and the Justice Institute examine the extent and magnitude of stress related factors,

through consultation with unit chiefs and attendants, particularly in the high call volume units and areas.

31. The Commission review hiring practices, taking into account local knowledge and concerns, delays in filling vacancies, and competition practices.

32. The Commission examine the merits of providing name tags and training classifications.

Chapter 11

COMMUNICATIONS - INTERPERSONAL

This aspect of the Ambulance Service is not without its problems. But, then, that is not uncommon within any organization, be it large or small. While all men may have been born equal, and while legislatures may attempt to pass in an affirmative sense, the fact of the matter is every person is different. Environments differ; conditions differ; perceptions differ; and certainly opinions differ. Properly managed, differences can be the strength of an organization; improperly handled, they can undermine and counter produce. Communication becomes the principle vehicle for constructing an operationally viable organization.

It was apparent to me in discussions with some of the people I met, that interpersonal communications had reached a low ebb. Much of that derived from misinformation and miscommunication. Some of it stemmed from attitudinal conflicts, personality differences, and downright failure to listen. Facts have a tendency to become distorted in those environments, and fact makes the difference between truth and fiction. It was difficult at times to determine the precise facts.

Complaints are the subject of a separate chapter here. But the principles or conditions stated above run true to those specific problems. Many of the complaints arose because of a lack of understanding. With roles unclearly defined and unexplained, it is no wonder there were differences of opinion. Ambulance personnel in some cases saw firefighters as interfering in the attendant's mandate to render pre-hospital care. Firefighters saw ambulance attendants as a hindrance in their rescue role.

In the heat of the moment, uncomplimentary observations would be made between parties. And over the days and weeks which followed, in the absence of an immediate and reasonable resolution, the cancer of misinformation would spread as the disease itself. While an oversimplification to state communication as the root cause, it nevertheless forms an integral part of the solution.

Organizations can have the finest of experts in the public relations field, and the glossiest of productions. They can also have the most explicit of instructions in manuals. But the grass roots, where as is said the rubber meets the road, tells the tale. One resolution lies within the training academies, where these matters should be discussed and the processes shaped and developed in the minds and attitudes of new employees. Another lies in the supervisory staff, where the conflict is examined and resolved, at the earliest and with reason. And then there is continuing education and consultation which is paramount.

I encountered fire departments and ambulance stations where there was absolutely no differences or conflicts. Both agencies expressed complete satisfaction with each other. And I asked myself, why? I encountered others where there was animosity and distrust. And I asked myself, why? Both were performing essentially the same public service in their respective roles; only the locations differed. . . and, of course, the personalities.

On the one hand there was good interpersonal communication. On the other, a complete lack of. In the first there were no unsolvable incidents, in the second, there were no solutions. The systems and conditions were the same, why not the environments? It was the people. I met separately with a unit chief and a fire chief at one location to find "everything is just fine between the two departments." I learned this to be so because they don't talk to each other . . . Fine? Management on both sides has the responsibility to identify these problems and afford it their undivided attention. The public expects and deserves no less.

Remarks were made respecting "Victoria's hidden agendas". One centred on the continuing threat of privatization, and that in spite of written documentation from no less than the Minister of Health and the Premier himself, assuring against such a move. When serious attempts to improve the system would be made by management, opinions based on either a lack of, or misinformation itself, increased suspicions and distrust. The cancer syndrome. In some of these instances, and for some personnel, there well may be no cure. For some, the deafness is a consequence of simply not listening; for others, not understanding; and yet others, for not wanting to listen or understand.

In the opposite vein, the visit to a unit station by the Deputy Minister of Health, evinced expressions of surprise and pleasure. As one attendant stated: "Mr. Dubas was interested enough in us to actually visit, speak and ride with us." Communication; and at the highest level. I am aware of the Executive Director of the B.C. Ambulance Service conducting extensive visits to local stations throughout the province. This can be time consuming and onerous - but it is absolutely essential if employee concerns and aspirations are to be addressed. Those visits should extend from the ambulance stations to the police and fire stations as well; and to the hospitals, the medical professions and mayors. This process need not be in the form of a formal audit, but rather as a genuine interest in determining the level and quality of service. It is significant from an organizational perspective, at all levels.

If the concerns I listened to at the local level were communicated internally, and equally important, if those concerns received responses, I am confident many of the problems arising external to the service would disappear. If employees are intrinsically happy within the service, that positive attitude would extend to the street and to the other agencies with whom they come in contact daily.

The Commission has a Manager of Public Relations located in Victoria. His responsibilities are set out in the Annual Report and appear to encompass both internal and external communications. That function ought to receive continued support and encouragement from within the Commission. However, one must never let this position and responsibility distract ambulance attendants from recognizing they are in the forefront of the public relations exercise. The general public, and certainly persons in distress, don't come in contact with the Manager of Public Relations. But ambulance attendants do. His office is a support to the field personnel, and from the evidence at hand it is good and useful support. While in a sense the sales manager, the attendants are the real sellers of the service through their daily interpersonal, interagency communications.

Communication is a vital part of the Commission. It is the serum which sustains life throughout all parts of the body, from head to toe. When one part of the anatomy is insufficient or fails to communicate, the pain is felt in other parts which relate to it. Individually and collectively then, it is the responsibility of one and all to make a conscious effort to ensure no one suffers, internally or externally.

RECOMMENDATIONS

It is therefore RECOMMENDED THAT:

33. The Commission and the Justice Institute incorporate a "Human Relations" segment into each of the E.M.A. levels of training.

34. The Commission establish a program which recognizes excellence, and all employees be encouraged to submit to their supervisors, noteworthy acts on the part of fellow attendants, police officers and firefighters.

35. The Commission, through the Minister or its Chairman, lay to rest the concerns surrounding privatization, by communicating officially to all employees.

36. The Commission, through the Chairman, address the Police Chiefs and Fire Chiefs at their annual meetings, with a view to opening a dialogue on mutual concerns and achievements, and motivated by a "working together" philosophy.

37. Regional Chiefs institute a visitation program whereby they visit each unit, at least annually, and simultaneously meet with local authorities to determine the level and quality of service and interdepartmental relationships.

Chapter 12

LABOUR RELATIONS

Normally an area "where angels fear to tread", I was fortunate to participate in good exchanges with the executives of both the Canadian Union of Public Employees (C.U.P.E.) and the Professional Firefighters Association (P.F.A.). While these two bodies have provincial, national, and even international connectors in the case of the P.F.A., I felt a particular need to confine my thoughts to the provincial landscape alone.

The main tenet of the executives appeared to place the emphasis on their respective members and "turf", so to speak. This did not strike me as unusual or unexpected. However, it had a tendency to cultivate the ground for conflicting and competing interests. Each also appeared to be inclined to attend to "their public", as if the person in need were somehow the singular responsibility of one body to the exclusion of the other. Actually that stance related not so much to the victim, but rather to their memberships and the perceived responsibilities of each agency. This caused me to examine this, once again, from the historical perspective.

Firemen previously performed emergency ambulance services. They attended victims in advance of the creation of the provincial ambulance network. Firemen responded to all types of emergencies, historically. That tradition and perception persists. Hence the P.F.A. stance.

E.H.S.C. personnel more recently assumed this response to emergency health situations. They are specifically trained and equipped for that singular role.

Firemen who persist in their traditional role, as opposed to the singular firefighting and rescue roles, were perceived as encroaching upon, and threatening, the livelihood of the C.U.P.E. membership. There was this mix of conflicting interests, in competition, whereas the reality of the situation is there is an overlapping of interests which actually complement one another.

Training is a prime example. The P.F.A. position of seeking E.M.A. training was perceived as a threat to C.U.P.E. members. "They are taking our jobs, our training budget, and our positions on these courses." Another was the contracting out to municipal fire departments. "We should be providing that service in those municipalities." In addition to what I have already stated in Chapter 7, it was interesting to note the fire chiefs expressed to me that they were not interested in taking these jobs. One stated: "Actually, when you look at it, they took our jobs."

There was a clear sense of two separate and distinct unions, or associations, vying for these "jobs." Hence the job action taken by C.U.P.E. at the Justice Institute, against firefighters from another union. Picket lines were established at the Justice Institute in Prince George and Smithers, to prevent firefighters from obtaining E.M.A. training. The administration did seek relief from the courts, but this was not forthcoming. In effect, union is pitted against union. There was no meeting of the minds, or common understanding between the two bodies. I learned in Campbell River that even C.U.P.E. was against C.U.P.E. This incurred the wrath of municipal authorities. Clearly an untenable and counterproductive environment.

It should be apparent to both unions that the two services, while distinct and separate, are not in competition. They are, rather, interdependent. It follows then, that firefighters must be afforded training commensurate with and complementary to that interdependency. To deny them that is to deny the public its right to health and safety. To deny the public this is unacceptable, untenable and, I suggest, perhaps illegal. The two bodies must recognize and accept this fact between the two services. Clearly defined protocols and job descriptions respecting the "First Responder" roles may, or ought to, clarify and correct this division of opinion. I would hope that could be done, primarily in the public interest.

The hostility is evidenced in the C.U.P.E. publication "CODE 3." A simple reading of that publication can lead to no other conclusion. There is a great deal of anger and frustration in the writings. This flowed over into the E.H.S.C., for some thought this to be an organ of the Commission. Some blame was consequently laid at the feet of the administrators within the Commission. Indeed, an untenable and unhealthy environment for all parties. One got a sense that the swamp would become so infested with alligators that the victim on the shore might be forgotten.

It is apparent that, without clear definitions of responsibilities, and clear pronouncements of policy and direction respecting training and contracts, this unsettling condition in emergency pre-hospital care will continue. I believe that, with the proposed first responder system, and the training to meet that, and a clear delineation of responsibilities between the two bodies, there is more than adequate support and goodwill in the ranks to overcome these actual and perceived labour differences. It appeared to me that the vast majority of the rank and file, on both sides, have the "man down" as their foremost thought. They were disappointed and dismayed at the agendas and open hostilities between the two bodies. They found these incidents and philosophies to be distracting, self-serving, counterproductive and not in the public interest.

Administrators in both agencies experienced these frustrations in a particular way. Much was beyond their control, for a variety of labour relations reasons. But I was again reminded that, in the majority of locations, there are no problems, the two parties work hand-in-glove in solving the problem immediately at hand. I found those agencies to have clearly defined terms of reference, good consultation and communication, in writing. And I asked myself why.

It is incumbent on all chief executives to ensure a meeting of the minds and thereafter a clear statement of policies, objectives and goals. This includes both levels of government, and agency executives. Those officers have the responsibility to communicate those policies, ensuring they are understood throughout the ranks, at all levels. The success story really begins there, for under that type of solid leadership, the troops will follow the guidelines with a sense of reliance and support for what they do on the street. I found a real willingness to serve the public, and to avoid the sometimes petty differences that get in the way of doing that.

I am confident that will diminish the erroneous perceptions and competing, conflicting interests which now do exist between the C.U.P.E. and the P.F.A. executives, and which can do nothing but create disharmony and discomfort amongst those in whom the public places so much reliance and trust.

Having found this situation to exist, and written what I have written, I am not inclined to make any recommendations to the Commission. It is beyond its control, and outside my expertise and purview. An angel, I am not.

Chapter 13

FINANCIAL CONSIDERATIONS

Finances are an important consideration throughout. They touch on every aspect of the administration and operation of emergency pre-hospital care. And they seemed to be a driving force, or at least an underlying motive, in many of the discussions. This was expected so I was not disappointed in that regard.

However, after all was said and done, I concluded that, from a philosophical standpoint as opposed to purely pragmatics, the provision of emergency pre-hospital care to the sick and injured ought not be, or perceived to be, a revenue producing entity. It is a public service to which every British Columbian has an entitlement in time of need. It can be a requirement which befalls any one of us at any time. It evolves from the "Good Neighbour" or "Good Samaritan" rule which must be maintained and cherished as a social norm. It is also a service which incidentally, is paid for and by the citizens through the tax structure.

The government of British Columbia has committed considerable millions of dollars of tax money to providing this service. The Commission's annual budget is over $60,000,000. In its short lifespan of fifteen years, well over half a billion dollars of the citizens' tax dollars have been spent in the creation and development of the provincial ambulance service. So it is serious business from a purely financial perspective. It indicates an emphasis on the value of life in this province, and as such must be maintained and supported.

Historically and currently, the other two emergency services, police and fire, consume a considerable portion of municipal budgets. A review of municipal estimates shows how the tax pie is divided, and how public health and safety are afforded major considerations. Those, too, have only one source of revenue: the taxpayer. At the provincial and local levels of government, it becomes obvious that the citizens, through their representatives, accept these services as necessities and that they are willing to pay for them through the two tax structures.

The question that frequently arose during these inquiries into emergency pre-hospital care concerned the division of financial responsibilities. Which agency should pay for which parts of the service? That I considered legitimate. Associated with the primary question was the issue of cost recovery. It became apparent that what was needed were clear delineations between the various agencies and responsibilities. This led to an anomaly.

The police services are separate and distinctly defined. The fire services are separate but perhaps less well defined. The ambulance service is separate and seeking to be well defined. Historically, the fire service assumed many of the emergency pre-hospital care services. It was also involved in rescue and continues so today. The ambulance service maintains a reliance on the fire, and to some extent on the police, to assist in these emergencies. The question which arises is: who pays, and who recovers the costs incurred as a result of these overlapping of services? This occurs as a result "the less well" definition between fire and ambulance services.

In the seven contracts, the answer is relatively easy. The Commission has agreed to pay them for providing a service which primarily rests with it. Not so easy are the other fire services. In fact, I received a submission from one fire chief touching on this very issue. He was stating a case wherein the Commission owed, but refused to pay, a considerable sum to the municipality for services rendered.

I think it necessary for a stand to be taken, one way or the other, on this type of financial issue. It may have to be reached at the political level, but a clear position must be adopted and promulgated. To avoid this is to place the Commission and its employees in an untenable environment vis-a-vis fire departments and its employees. But perhaps before that, the various responsibilities ought to be clearly defined.

The first responder situation is a case in point. Some fire departments are asked to respond and do so. Others are not asked to respond and still do so. Some which are asked to respond, ask for repayment. Many departments do not ask for repayment. The police never ask for a recovery of costs in responding. It is not a clear cut issue in some locations. Let me explain why. Some fire departments, even in large municipalities, have a mix of regular and volunteer members. When a first responder call is placed by E.H.S.C. to that department, volunteers are called to the fire hall to "back up" those who have responded to the ambulance call. They are paid for attending in that manner; I heard the rate to be even "double time." The cause of that cost to the municipality was an emergency health care - not a fire. Hence the argument the province should pay.

Historically again, and prior to the present ambulance service, no payments were involved. The two emergency responders were compensated by way of the municipal tax route; it was a normal part of their duties performed in the normal course thereof. It was also a part of the "Good Neighbour Rule", supported during the course of these inquiries by many firemen alluding to "going to the assistance of one of our citizens."

However, with the advent of the Health Emergency Act, with all its trimmings and including financial resources, there seems to have developed a sense that because this responsibility attaches solely to the Commission, when called upon to assist that agency, payment should be forthcoming. Given the history, I find this anomaly difficult to reconcile.

When a citizen of this province pays for emergency services he expects a response. When a policeman is injured, and another policeman acts as a first responder, he doesn't bill the ambulance service for that action. When a fireman is overcome with smoke or injured, he doesn't bill the ambulance service for the first response. And when a citizen is injured, and a policeman or fireman responds first, the citizen doesn't expect the policeman or the fireman to bill him or the ambulance service for attending. That citizen has paid his provincial and municipal taxes and thus expects that service, whatever it might be, to have been paid for.

The First Responder system, by its very nature within the total emergency response concept, implies the service to be forthcoming and without remuneration. The general public expects the three professional services to be capable of responding, and to respond. He has paid for that service. This service should not be a revenue producing service. I ask why the police do not expect repayment. I ask why some fire departments do expect repayment. I ask on behalf of the taxpayer. What you miss in the swing, you pick up in the round.

In the more specific area of the seven contracts, and at other fire halls where the Commission has stationed ambulances, without a written contract, payment is made to those agencies for providing ambulance services in lieu of the Commission's duty. That is a reasonable expenditure. Whether the financial return is fair and reasonable is a question between the contracting parties. Some maintain it is, others do not. In some instances the remuneration pays for calling out "standby firemen" to be at the hall in the place of firemen called to attend with the ambulance. The fiscal and manpower arrangements are left to the municipalities and departments to manage. All the Commission desires is a response to the incident when dispatched, and a service to the person in need of pre-hospital care. How the municipality or department manages the funds provided in these cases is not within the authority of the Commission. The municipal authorities are accountable to the municipal taxpayers.

Having said this, in my discussions with municipal authorities it appeared there might be a better method for remuneration of services. While perhaps an over-simplification, a lump sum annual payment might be more effective and expeditious than a "per call" arrangement. I say this because there is a general perception that the dispatch centre favours sending an ambulance from an E.H.S.C. unit for cost effectiveness, when it might have been more efficient and effective to send a contracted ambulance. Case in point: a patient in Nelson was to be transferred to the Trail hospital. The Trail ambulance was dispatched to Nelson. It returned to Trail too late for the patient's CT scan - the technician had left for the day. Had the patient been transported by the Nelson ambulance, he would have been attended to. There were other instances of this type with the service being criticized. The argument was based on cost saving; but Trail was apparently without an ambulance service during this period.

If dispatch were not burdened by cost saving concerns, but rather dispatched the nearest ambulance and that service were, in a sense, pre-paid, the citizenry would probably be better serviced. I appreciate the financial ramifications, but such stories were related in the interests of efficiency and costs. Instances such as this could be reviewed by visiting the various units and discussing the issues with the local authorities.

The position often posed during these inquiries was that firemen can perform emergency pre-hospital services, or the ambulance service, more effectively and at less expense, than the current arrangements allow for. The principal arguments in favour of that stance were:

(a) response time;
(b) manpower;
(c) facilities; and
(d) local knowledge.

Manpower and facilities are major financial considerations which consume a large part of the Commission's budget. What the firemen required to bolster that position was equipment and training. The historical aspect was also argued: "we did it before." In the case of the seven contracts, it was argued that if the Commission were to locate and staff ambulance stations at these points,it would cost them much more than it now costs.

In purely financial terms, there is merit to the arguments. I believe it would cost more in the overall. But as I stated earlier herein, the financial considerations are but one in a host of many. First and foremost is the service itself.

A province-wide ambulance system was established to provide uniform and consistent emergency pre-hospital care in all quarters of this province. It is not constrained by jurisdictional boundaries. It even incorporates a province-wide air-ambulance system. Treatment is intended to be consistent for all, and throughout the province. While perhaps never completely and fully achievable, it nevertheless remains a policy and goal of the provincial legislation.

There is no doubt it costs a great deal to provide this service. But one need only look back at the level of service provided in yesteryear, and compare it with the state of the art, the equipment and the qualifications of the ambulance personnel today. There is no comparison. The day of "scoop and run" has passed on and been buried.

Established now are the three essential emergency services; police, fire and ambulance. Each is distinct and separate, although necessarily interdependent. The police agencies recognize and accept this; the fire chiefs recognize and accept likewise; and the Ministry of Health and the provincial government clearly accept. Some agencies and some personnel would like to retain the service for the reasons stated earlier.

The Commission and the service is now up and running. It will improve with age, just as the police and fire services have. It will obtain better and more facilities; it will train and equip to higher levels; it will improve the response times with more personnel and equipment and facilities. This all takes time, money and planning. To revert to the former state, having gone this far and expended that much, would be fiscally irresponsible. The citizens, as taxpayers, have become accustomed to a higher level of service and I suggest, would be adverse to any balkanization of the service at this juncture in the development of emergency pre-hospital care.

Those persons who plead for a return of the ambulance service to the fire halls are well intentioned from the local perspective. I respect their motives, indeed, admire their genuine desire to provide the best possible service in their particular communities. They have an affinity with the local residents; that is commendable. But when considering the bigger picture, parochial perspectives must sometimes accede to the provincial frame. What the provincial service must do is ensure those local needs are addressed. There are a variety of ways this can be done, starting with consultation and communication.

It is appropriate here to quote from the 1974-75 inquiry into police and fire services. At page 55, Mr. Keenleyside made the following observation in relation to combining policemen and fire men into one department. He was alluding to the municipality of Esquimalt.

> "The case of Esquimalt is somewhat unusual because of the availability of the Dockyard fire fighters (though only on a second-call basis) but most of the participants in the

> Esquimalt department are policemen who are saddled with jobs that they do not feel competent, and do not wish, to perform. Such a combination is wrong in principle. For real efficiency the practice of "one man one job" should not be lightly abandoned. As Plato wrote 2400 years ago, "More will be accomplished, and better, and with more ease, if every man does what he is best fitted to do, and nothing else."
>
> "Fire and police services are each too important to be left to men who can give to each only half a mind."[1]

Those observations were made in 1975, when the provincial ambulance was born. The same principles apply in 1989, but perhaps more so now that the ambulance service is reaching maturity.

In my discussions with firemen and ambulance attendants alike, there was a clear consensus that they wanted to be either one or the other. They didn't want to give "half a mind." But they saw no difficulty in assisting each other in their respective roles; indeed, they saw it as functionally essential at times. Mr. Keenleyside goes on at page 115:

> "Fire departments have traditionally provided rescue, first aid and resuscitation assistance to the public. They are organized for immediate response and in many communities are the only persons who are so quickly available. In an emergency they can provide immediate assistance, and this life-saving capability should be recognized and exploited wherever a strong, separate ambulance service is not established.
>
> "In cases of necessity it can be of the greatest benefit to the general public to be able to call on a fire department for emergency assistance.

---

[1] The Fire Fighting Services in British Columbia - Report to Attorney General; Hugh L. Keenleyside, Victoria, May 31, 1975

> "Police forces, the Provincial Emergency Programme, the Government Ambulance Service and the fire departments should understand their respective functions and capabilities and should work together in harmonious cooperation. In order to make this possible the role of each service in emergency circumstances should be clearly defined at the local community level. The general public should be made aware of the function of fire departments and their relationship to the ambulance and other services. This is important in order that the public can call upon the services on the most appropriate priority basis."

Fourteen year later the same principles apply. But adjustments in the likes of the 911 system cause amendments. The First Responder system discussed in an earlier chapter has this in mind. Fire departments can continue to provide this service to the general public, complementing the ambulance service as it exists today.

Combining the services is what we have today in the seven contracted municipalities. Combinations also exist at other locations under less formal arrangements. Financial considerations become secondary to the main issue: providing a provincial service. The time has come to bite the bullet and make clear, well thought out and articulated decisions. Consultation and communication, once again.

The Commission will require more in the way of financial resources if it is to succeed in the final analysis. It must plan strategically with that in mind. There will be a requirement for more full time employees, more training, more equipment, more stations; but this will take time and requires extensive fiscal planning.

RECOMMENDATIONS

It is therefore RECOMMENDED THAT:

38. Under the "First Responder" arrangement, Fire Departments and Police Departments attend under the "Good Samaritan" rule, without compensation from the Commission.

39. The Justice Institute program for "First Responders" receive an adequate and appropriate infusion of funds to allow for the training of police and fire personnel, at no cost to the municipalities.

40. The Commission examine the fiscal arrangements with contracting municipalities, with a view to simplifying and ensuring the cost effectiveness does not detract from an adequate level of service.

41. The Commission plan, strategically, its financial requirements in the light of its continuing growth and development.

Chapter 14

COMPLAINTS

A complaint, is a complaint, is a complaint. Never less, but sometimes much more. No living organization is without them. At least, it is a sign that an organization is doing something; the complainant just doesn't agree with how it is being done.

Attention to complaints is one test of the strength of an organization. Reasonable introspection, a willingness to listen, and a desire to right wrongs can serve to strengthen the corporate body. Policy changes can result and enure to the benefit of all users. Complaints can serve as a barometer in changing environments.

During my discussions with various personnel, both internal and external to the pre-hospital emergency health care system, I heard many "complaints." Some have undoubtedly been addressed. Others may not have been and some were probably raised from dormancy as a result of these inquiries. The very fact people came forward and discussed them led me to ask if there exists an adequate system for attending to them. I thought also it would be beneficial to record them so that the reader could get a flavour of the difficulties some people were experiencing. The facts may be in dispute; but the very fact they play on some minds, is cause for deliberation. For easy reference, and without commenting on the merits of each, I have incorporated them at the end of this chapter.

Generally speaking, complaints can be classed as minor or major, and require resolutions in an informal or formal manner. Some organizations have developed fairly large bureaucracies to deal with complaints. In my view that is a sign of weakness. It indicates the organization has not addressed the complaints from a causal perspective; rather it elected to deal with them symptomatically. It were better if the causes were treated, than simply continue to administer to the symptoms.

Many complaints are minor in nature and resolvable informally at the local level. This is done, in fact, in most instances. Reason and common sense prevail for the most part. There are cases in which individuals do not, however, have an inclination towards those attributes. They are best identified as being more part of the problem than part of the solution. They shall always be around to try others and the organization. Regardless, local administrations are best left to informally resolve local problems, be they people problems or systemic problems.

Training in the care and handling of complaints should form part of the curriculum at the Justice Institute. It may take only an hour, but it would serve to raise the level of consciousness of staff to this inevitable fact of life. Training in human relations, at the grass roots and supervisory levels, would go a long way in the resolution process. It would also stem the flow of complaints into the upper reaches of the administration. It is important to recognize that, nowadays, if the problem is not resolved expeditiously at the local level, the complainant will probably pursue it to higher heights, internally and externally, until he captures a sympathetic ear.

I heard from several parties that it appeared to them the ambulance personnel were "keeping book" on the firefighters. This resulted from a supervisors' meeting with fire administrators. A "long list of complaints", some or most of them dated, was presented to the fire officials. Regardless of the circumstances, it points out the need to communicate and reach individual resolutions at the earliest mutual convenience. To do otherwise creates airs of suspicion and distrust between persons and agencies. This, surely, is not in the interests of the organization.

Major complaints requiring formal resolutions deserve more serious attention on the part of staff and the administration. I note where, in 1988, some 59 complaints were investigated by the Inspections Branch of the Commission. These would obviously be cases which were drawn to the attention, formally, of the Commission. Clearly, at this level the complaints are formally received and responded to. A mechanism is in place to deal with this.

The same principles apply to formal and informal complaints alike. However in the more serious, formal mechanism, the inspectors are at the forefront. They must conduct an investigation, examine and determine the facts, and proffer resolutions. It is important thereafter for the administration to convey those findings and resolutions to the complainant. This should be done through the offices of the Executive Director or the Chairman of the Commission. The complainant is then aware that his concerns have been addressed at the highest level of the organization.

Thereafter, what the Commission should be left with is a repository for complaints, their nature and extent, the resolutions reached, and any action taken as a result. This would serve as an information base for supervisors and the training of personnel. It is an excellent mechanism for introspection and examination of policies and procedures. We all make mistakes; the question is: do we learn from them? A systematic complaint handling process can assist in that. The lessons learned must be communicated both upwards and downwards in the organization, all without becoming too bureaucratic or insensitive in the course thereof.

RECOMMENDATIONS

It is therefore RECOMMENDED THAT:

42. The Chairman establish policy for the handling of complaints, incorporating the following therein.

43. The Inspections Branch of the Commission be the central repository for all complaints made against the service, and that all complaints received in writing at the unit and regional levels be forwarded to that Branch for review.

44. Where a resolution is not reached between the parties at the unit and regional levels, the Director of the Inspections Branch undertake inquiries respecting that complaint.

45. The Director, following appropriate inquires, submit his findings and recommendations to the Executive Director and the Chairman, for resolution and decision.

46. The Executive Director or Chairman convey that decision to the complainant, in writing.

47. The Justice Institute have access to the Director of Inspections and the central repository, for the purposes of instruction at the Institute, and that unit chiefs and regional supervisors be trained in the investigation and handling of complaints.

The following "complaints" were proffered by various individuals during the course of this inquiry. The sources of these statements are appropriately identified.

Ambulance Personnel

1. Ambulance being run off the road.
2. Fire trucks blocking access to the scene.
3. Firefighters blocking access to the patient.
4. Firefighters orchestrating scenes for public image.
5. Firefighters leaving the access door to high rise locked and taking the building manager with them.
6. Firefighters using up the available space for parking in front of a building.
7. Central Regional Dispatch on receiving a call for an ambulance for a person suffering a heart attack kept the person on the phone, running back and forth trying to get information from the other civilian attendant.
8. Training of firefighters is a step to privatization.
9. Firefighters are using up our training budget.
10. Firefighters are taking positions on training courses and our own people are cancelled.
11. Firefighters in their role of First Responders are for most part a hindrance rather than a help as they do not pass on the correct information on the arrival of E.H.S.
12. Complaint handling is a laugh, E.H.S. personnel come on like gangbusters: "It's your fault."
13. Firefighters are taking our jobs.
14. As part timers, we take the training, remain on call, but E.H.S. won't call us out because of money.
15. E.H.S. does not give the part timers any credit for local knowledge.

16. In a local competition, someone down on the mainland gets the job, I had the same training.
17. All First Responders should have a name tag with their training level so you know who you are dealing with.
18. We don't care what the firemen think. If they withdraw their services, we could handle it with the regular and part time workers we have.
19. Firemen take the ambulance to a fire call when there is no report of injuries.
20. Firemen, on attending fires, book their ambulance off duty.
21. Firemen should not be cross-trained. Why don't we carry hoses in our ambulances and fight fires.
22. E.H.S. does their planning in a vacuum.
23. Firemen use a sticker program. They leave stickers on fridges, doors etc., "You have been assisted by your Fire Department."
24. We are not to discuss anything about E.H.S. outside of our own chain of command. Therefore, we rarely get good public relations on our service.
25. E.H.S. did not give me a response to a complaint. I took my own time to write up.
26. We are not asked to write comments for good service outside E.H.S. Our headquarters doesn't seem interested. I went to a fire hall on my own and conveyed my comments to the senior fireman on duty.
27. We were assigned small office space in the hospital without water or washroom facilities. They are only accessible down a long hall.
28. Communications with senior staff at Headquarters is non-existent.

Fire Personnel

29. Ambulance personnel interfering with rescue operations.
30. Ambulance personnel entering an unsafe area as rescue operation was in process.
31. Calls are being stacked, by Provincial Dispatch and E.H.S., in northern area. Had to field frivolous complaints why they took so long.
32. Calls are being stacked by Central Regional Dispatch when the calls are for the contractor. They see the emergency light come on their phone and sit and wait for Provincial Dispatch to call them. One up to 17 minutes.
33. Central Regional Dispatch does not give any weight to local knowledge.
34. Central Regional Dispatch cannot know the day to day changes in a community, such as road conditions, weather, construction, street closures and local areas do know by local names.
35. Central Regional Dispatch called the ambulance for a man who had collapsed on the street, they did not call fire hall across the street who could have attended as a first responder.
36. When a complaint is received, E.H.S. drops a whole bundle on us, they appear to be making book on us.
37. E.H.S. personnel had the ambulance parked at his house at 10:00 a.m. and was cutting his lawn.
38. Our one man station is going to have a nervous breakdown. He's trying to do a good job but has difficulty with on call part time people. He never seems to get a break. We would drive for him, if he asks us but we feel E.H.S. don't want us involved.

39. E.H.S. uses the divide and conquer tactic in discussing contracts and their content.

40. E.H.S. will call on Friday and I have to spoil my weekend to be in their office on Monday morning.

41. The E.H.S. union blocked our members from attending a school of higher learning and E.H.S. didn't do anything about it.

42. When local people phone our fire hall for assistance we have to phone Regional Dispatch and sometimes we aren't called out. Later we hear the ambulance didn't get there until quite a bit later.

43. I would rather talk to a local person than talk to someone I don't know in Kamloops, Vancouver or Victoria. We get better service from our own.

44. We can supply ambulance service in our area cheaper and better than E.H.S.

45. As first responders, we get very few calls, E.H.S. want it all for themselves.

46. When the ambulance passes us it tends to ruin our image.

47. We will not agree to token training, we want access to E.M.A. training and no less.

48. We don't want E.M.A. III training for our firefighters as we can't be away from our station that long. Remember we are firefighters first.

49. For the most part, we are being kept in the dark. Their legislation and procedures are being shoved down our throats, "Do it our way or we'll take over."

50. E.H.S. needs us but their dispatchers want absolute control. They have become dictatorial.

51. We become angry when we see silly games being played by E.H.S.

52. They call us when they have a heavy patient so we can carry the stretcher for them.

General

53. Ambulance and fire vehicles racing to the scene.
54. A busy signal on the northern hard wire lines for four hours, when dialling the emergency ambulance number on Mother's Day, 1989.
55. We do not know what Victoria's "hidden agenda" is.

Chapter 15

SUMMARY AND RECOMMENDATIONS

The two predominant words which caught my attention throughout this inquiry were communication and consultation.

Those action words were the antithesis of every negative thought and comment in these discussions. Phrases like "hidden agenda", "out of touch", "they don't understand" were not uncommon. From the misunderstandings and misconceptions grew animosities within and without the organizations. And that is where the greatest damage is done. When negatives surface, they have a tendency to grow and spread.

A major part of the solution lies in not waiting for the misunderstandings to arise, but rather in establishing open communication and consultation as a matter of normal practice, before the fact. Meetings which are called to solve problems are an indication of a shortfall in the system in the initial instance. Policies and procedures which are devised in isolation, without consultation, can only give rise to questions and misconceptions. It is much easier to resolve issues when you know the parties you are dealing with, beforehand. It is much easier to consult with parties when the lines of communication have been opened in advance. One party must take that initiative, and I suggest the time is ripe for the Emergency Health Services Commission to do just that, internally and externally.

In viewing this whole scenario from a damage assessment perspective, it is nowhere near what some would have the Commission to believe. The B.C. Ambulance Service is an excellent service for which the Commission can be justifiably proud. Certainly there are shortcomings. There is a need for more equipment, more facilities, more personnel and more training. This takes time, money and planning . . . and of course, consultation.

The Ambulance Service was recognized throughout these discussions as an essential emergency service. It was acknowledged by the two other emergency services, police and fire, as good and necessary, forming a tripartite service to the public. Save for a very few persons, the remaining 99% appreciated the distinctive roles of the three services. They have no intention of "taking jobs", "assuming control", etc., of the ambulance service. Conversely, I found no indications of the Commission seeking to relinquish its mandate to other agencies, to "privatize", or to otherwise diminish its mandated responsibilities under the Act and Regulations. Nevertheless, these were major misconceptions on the part of a few, pushed to the limit by those few, and the source of considerable discomfort to the many who were left in wonderment. Those sensitivities must be laid to rest. COMMUNICATION and CONSULTATION.

There were herein, and shall remain in the future, conflicts between individuals. Some people are simply that way; it's their "vitamin E". But it's also up to management at all levels to ensure they don't fall into that class, and secondly to identify and correct those who do. Those who foment dissent should be encouraged to climb aboard and sail with the majority who just want to do a sound professional job. The vast majority of ambulance attendants respected and welcomed participation by the firefighters. And the Fire Chiefs and officials whom I consulted, respected and acknowledged the work of the ambulance attendants. Hopefully some of the recommendations made here will go to cementing that kind of mutual understanding and respect.

On June 28, 1989, I received a submission from the British Columbia Fire Chiefs Association and the G.V.R.D. Fire Chiefs Association. I obtained the permission of Vancouver Chief D. Pamplin to include that report as an appendix to this, and do so as Appendix D. I allow it to speak for itself, without editorial.

I believe the "First Responder" program, discussed herein, shall permit all firefighters the opportunity to share in the continuation of the "Good Samaritan" service to members of "their community." This role, which has been ingrained in them by their predecessors and whose boots they now fill, will only enhance their status in the eyes of an already appreciative public. Fire Chiefs and firefighters have a continuing opportunity to exhibit to the public, but more particularly to the person in need, that their "First Responder" skills are professionally designed to assist that person in pre-hospital emergency care, from a team approach.

The contractors, likewise, in handing over their previously held responsibilities to an advanced life skill group, can only gain greater respect from members of the public they have served over the years. This transition, managed professionally and with confidence, has a greater potential to benefit all involved in this process. Experiences in other jurisdictions, be they Canadian or American, were created and developed to suit their particular needs. While complimenting them, one must recognize that the system developed in British Columbia was created to meet our local and provincial needs. We can emulate the others, but it does not necessarily follow that we should now adopt or superimpose those systems here. If that were to have been done, it should have occurred fifteen years ago. Such was not the public will then, and with the legislation in place and extensive developments having occurred in the interim, we should not now be inclined to turn the clock back. The province is blessed with three excellent emergency services, each distinct but with the collective public good in mind.

Likewise the contracting municipalities should not be looking to the Commission for financial support in their firefighting services. Over a million dollars is currently expended by the Commission in these seven contracts. Granted this assists the Commission in its mandate; and I suggest it also assists those municipalities in meeting their fire suppression responsibilities. The latter is of purely municipal competence and ought to be treated as such. The "First Responder" proposal recognizes and emphasizes this, and lends a sense of equity to all Fire Departments in the province. Each level of government ought to ensure it meets its particular responsibilities and spheres of influence in the public interest.

Finally, I reflect on a thought which crossed my mind when I undertook this task, and to which I alluded in the introduction. Mine was a informal inquiry as opposed to a full scale "Judicial Inquiry."

The latter is a process called upon when there is a lack of public confidence in a system. It is intended to be an open, public forum, to allow members of the public a voice for their concerns and lack of confidence. The present inquiry was a cursory examination of the system, where an opportunity for some, by no means all, of the participants to voice their concerns about the system.

Having communicated and consulted with those persons, I am of the firm view that the British Columbia Ambulance Service, while not perfect in all respects, is nevertheless a service which the public can respect, and have trust and confidence. While logistically it was impossible to meet with everyone, to examine in detail the finances, to test the systems scientifically, there was more than sufficient information available to cause the above conclusion and to warrant the recommendations herein.

I wish the three emergency services every success in the performance of their respective responsibilities. And more particularly the B.C. Ambulance Service, and the Commission, as they continue to grow and develop a truly professional emergency service for all residents of this province. It is my hope the observations in this report will assist in those respects.

SYNOPSIS OF RECOMMENDATIONS

1. The Chairman of the Emergency Health Services Commission consider recommending to the Lieutenant Governor in Council, the appointment of two additional members to the Commission, and that each of these persons be drawn from the police and firefighter services, to attend Commission meetings in an advisory role.

2. The Commission review and consider the creation of more administrative centres, in particular to cover the northern and eastern reaches of the province, and to ensure local concerns are more personally and directly addressed at the local level.

3. The Commission review its "Code 2(B)" performance level and either:

   (a) increase its equipment and manpower capabilities, and utilize that service as a training enhancement in the service and back-up for emergency services; or

   (b) abandon that service in favour of the private sector, and concentrate singularly on providing emergency services only.

4. The Justice Institute examine the re-certification program and while not sacrificing content and quality, modify its delivery taking into account actual and realistic local conditions and experiences.

5. The Commission and Justice Institute consult the contracting municipalities to ensure the most effective and economical process for training and licensing of firefighters to the E.M.A. II level.

6. Police and Fire personnel continue to perform a First Responder role in emergency pre-hospital care cases.

7. The Commission develop specific operational protocols between police, fire and ambulance services, with particular attention to dispatching to the scene; and that regional administrators thereafter consult and communicate with the local authorities to ensure understanding and compliance with those two authorities, police and fire.

8. The policy clearly enunciate that, if an ambulance cannot respond immediately and within a reasonable time frame, as the First Responder, the dispatcher ensure a police and/or fire First Response, immediately.

9. The Commission examine its statistical data respecting response times, using that data as an informational guide for resource purposes as well as an instructional guide for attendants.

10. The Commission, in concert with the Justice Institute, develop a First Responder course (P.F.R. - E.F.R. - Medic I/II) for police and firefighters.

11. The training, travel and living expenses for attendees be underwritten by the Commission.

12. The wages of municipal employees attending this course be underwritten by the respective municipalities.

13. Consideration be given to conducting these courses, or portions thereof, locally, in order to reduce costs and inconveniences to municipal employees.

14. Consideration be given to training instructors in the First Responder system, at the local level, on the principle of "each one, teach one" to encourage wider community participation and support.

15. The Commission, in the case of Greater Victoria Regional District, adopt the same structure and system in providing ambulance services, as exists in the Greater Vancouver Regional District.

16. The Commission consult with the municipal authorities in Oak Bay and Saanich, with a view to terminating those respective contracts at a mutually convenient time, but not later than the life of the existing contracts, and thereafter provide a provincial service to those communities commensurate with their needs, from a Greater Victoria or capital region perspective.

17. The Commission examine the existing arrangements at View Royal and Central Saanich, with a view to doing likewise at those locations, and providing one centralized service in the greater Victoria region.

18. The Fire Departments at Oak Bay, Saanich, View Royal and Central Saanich adopt the First Responder method to medical emergencies in their municipalities, as recommended in Chapter 6.

19. The existing contracts at Port Alberni, Campbell River, Kitimat, Fort St. John and Nelson, remain and continue in force until such time as the Commission can establish permanent, full time units at those locations; and that the Commission and respective municipalities consult and be mutually assured that the service to be provided will be commensurate with, or exceed, the service currently provided.

20. When establishing units in the above five municipalities, consideration be given to hiring medically trained firefighters within the ambulance service at those locations.

21. Those five municipalities thereafter participate in the First Responder program, and that they have the first opportunity to receive, at no cost to the municipalities, emergency vehicles disposed of by the Commission, in a dual "rescue-first responder" role.

22. The Commission undertake to provide emergency medical training and licensing, to the E.M.A. II level, to members of the above five contracting municipalities, for the life of these contracts, in order to ensure compliance with the Act and Regulations, and at no cost to the municipalities as recommended in Chapter 5.

23. The Commission consider donating emergency vehicles which are no longer needed by the Commission, and are slated for disposal by the Commission, to municipalities which could utilize them most effectively in a dual "rescue-first responder" role.

24. The Commission, in consultation with B.C.B.C, develop a manual to serve as a construction guide for ambulance stations, and which would include site selection data for use in consultation with municipal planners.

25. The Commission develop a strategic plan, encompassing up to 20 years, in which the establishment of ambulance stations is predictable and foreseeable, and for which adequate funding and manpower requirements can be assured.

26. The Commission continue strategic planning in the latest technology by ensuring adequate funds are available and the expertise to deliver the product is so encouraged.

27. The Commission, through its administrators, ensure adequate supervision and control in dispatch centres to assure immediate responses, a gaining of local knowledge and conditions, the first responder system is complied with, and the stacking of calls is discouraged to the lowest minimum.

28. The Commission review all "one person stations" by consulting those unit chiefs, with a view to increasing support and reducing the stress and tension.

29. The Commission review the lot of part-timers and volunteers, by consulting with them respecting their frustrations and expectations.

30. The Commission and the Justice Institute examine the extent and magnitude of stress related factors, through consultation with unit chiefs and attendants, particularly in the high call volume units and areas.

31. The Commission review hiring practices, taking into account local knowledge and concerns, delays in filling vacancies, and competition practices.

32. The Commission examine the merits of providing name tags and training classifications.

33. The Commission and the Justice Institute incorporate a "Human Relations" segment into each of the E.M.A. levels of training.

34. The Commission establish a program which recognizes excellence, and all employees be encouraged to submit to their supervisors, noteworthy acts on the part of fellow attendants, police officers and firefighters.

35. The Commission, through the Minister or its Chairman, lay to rest the concerns surrounding privatization, by communicating officially to all employees.

36. The Commission, through the Chairman, address the Police Chiefs and Fire Chiefs at their annual meetings, with a view to opening a dialogue on mutual concerns and achievements, and motivated by a "working together" philosophy.

37. Regional Chiefs institute a visitation program whereby they visit each unit, at least annually, and simultaneously meet with local authorities to determine the level and quality of service and interdepartmental relationships.

38. Under the "First Responder" arrangement, Fire Departments and Police Departments attend under the "Good Samaritan" rule, without compensation from the Commission.

39. The Justice Institute program for "First Responders" receive an adequate and appropriate infusion of funds to allow for the training of police and fire personnel, at no cost to the municipalities.

40. The Commission examine the fiscal arrangements with contracting municipalities, with a view to simplifying and ensuring the cost effectiveness does not detract from an adequate level of service.

41. The Commission plan, strategically, its financial requirements in the light of its continuing growth and development.

Appendix "A"

HEALTH EMERGENCY ACT

CHAPTER 162

[Act administered by the Ministry of Health] *[Consolidated September 6, 1985.]*

Interpretation

1. In this Act

"commission" means the Emergency Health Services Commission;

"minister" includes a person designated in writing by the minister;

"emergency medical assistant" means a person licensed by the commission under this Act as an emergency medical assistant;

"ambulance" means a conveyance that is used, or intended to be used, for the purpose of transporting persons requiring medical attention or under medical care, and that is designed and constructed, or equipped, for that purpose;

"municipality" includes a village municipality;

"emergency health service" means the provision of first aid or medical services in emergency situations.

1974-30-1; 1985-9-4.

Commission

2. (1) The Emergency Health Services Commission is continued.

(2) The commission shall be composed of one or more members appointed by the Lieutenant Governor in Council.

(3) The Lieutenant Governor in Council may

- (a) establish the terms and conditions of the members' appointments under subsection (2), and
- (b) designate a member of the commission as chairman.

(4) A member of the commission is entitled to his necessary and reasonable travelling and living expenses incurred while exercising his powers or performing his duties.

(5) The minister may appoint a person who, in the event that a member or the chairman of the commission is unable to act from any cause, shall act temporarily in the place of the member or chairman and exercise his powers and perform his duties.

1985-9-5.

Agent of Crown

3. (1) The commission is, for all purposes, an agent of the Crown in right of the Province.

(2) The commission may, as agent, carry out its powers and duties under this Act in its own name and may purchase or otherwise acquire and hold in its own name personal, and, with the prior approval of the Lieutenant Governor in Council, real property required for the purpose of the commission, and likewise may sell, transfer, lease or otherwise dispose of, the property.

(3) The commission, as agent, is a legal entity.

1974-30-3.

Staff

4. (1) An executive officer of the commission shall be appointed by the Lieutenant Governor in Council and shall be paid remuneration for his services on behalf of the commission as determined by the Lieutenant Governor in Council.

(2) Subject to the prior approval of the minister, the commission or, if authorized by the commission, the executive officer may, notwithstanding the *Public Service Act*, appoint officers and employees and engage and retain specialists and consultants considered necessary to carry out the duties and functions of the commission and may determine their remuneration.

(3) The *Public Service Act* and the *Public Service Labour Relations Act* do not apply to the commission or its officers and employees appointed under subsection (2); but the Lieutenant Governor in Council may, by order, direct that some or all of the provisions of the *Pension (Public Service) Act* apply to the executive officer and some or all of the officers and employees of the commission, and the provisions of that Act shall apply accordingly.

1974-30-4.

Power and authority of commission

5. (1) The commission has the power and authority to

(a) provide emergency health services in the Province;

(b) establish, equip and operate emergency health centres and stations in areas of the Province that the commission considers advisable;

(c) assist hospitals, other health institutions and agencies, municipalities and other organizations and persons, to provide emergency health services and to train personnel to provide services, and to enter into agreements or arrangements for that purpose;

(d) establish or improve communication systems for emergency health services in the Province;

(e) make available the services of medically trained persons on a continuous, continual or temporary basis to those residents of the Province who are not, in the opinion of the commission, adequately served with existing health services;

(f) recruit, examine, train, register and license emergency medical assistants;

(g) provide ambulance services in the Province; and

(h) perform any other function related to emergency health services as the Lieutenant Governor in Council may order.

(2) No person shall, except with the written consent of the commission and on terms it may specify, do anything that the commission is given the power to do under subsection (1).

(3) Subsection (2) does not apply where a person is acting in connection with the provision of industrial first aid in accordance with the requirements of the *Workers Compensation Act* or regulations made under that Act.

1974-30-5; 1985-51-28, effective July 11, 1985 (B.C. Reg. 221/85).

Practise of medicine by emergency medical assistant

6. Nothing in this Act authorizes a person not registered under the *Medical Practitioners Act* to practise medicine; but where the unavailability of a medical practitioner is likely to result in a person's death or deterioration of health, and an emergency medical assistant is available, he may perform emergency procedures that he has been trained for and that he considers necessary to preserve the person's life or health until the services of a medical practitioner are available.

1974-30-6.

Licence required

7. No person shall assume or use the title "emergency medical assistant" or otherwise represent himself to be an emergency medical assistant unless he is the holder of a valid and subsisting licence under this Act.

1974-30-7.

Annual report

8. The commission shall each year submit to the minister a report for the preceding calendar year respecting the operation of the commission.

1981-20-38; 1984-19-2.

Regulations

9. (1) The Lieutenant Governor in Council may make regulations, including regulations

- (a) respecting the qualifications, examination, training, registration and licensing of emergency medical assistants;
- (b) prescribing fees payable for any service rendered, or a licence issued, under this Act;
- (c) respecting the equipping of emergency health centres and stations;
- (d) establishing standards of construction and maintenance required for an ambulance, and may establish classes of ambulances and set different standards for those classes; and
- (e) establishing the standard of equipment and supplies to be carried in an ambulance while it is being used or held out as being available for use as an ambulance.

(2) The commission may, with the prior approval of the minister, make rules governing its own procedure as it considers advisable.

1974-30-9; 1983-10-23, effective October 26, 1983 (B.C. Reg. 393/83); 1985-51-29, effective July 11, 1985 (B.C. Reg. 221/85).

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Province of British Columbia
QUEEN'S PRINTER

QUEEN'S PRINTER LIST OF CONSEQUENTIAL LEGISLATIVE AMENDMENTS

F-I

NOTE: This list is printed for convenience only and has been consolidated as of: DEC 17 1987

Amended by	Section	Amended Acts and Amendments	Effective Date
BILL 59 1987	5.	**Funds Control Act** Section 3 of the *Funds Control Act*, R.S.B.C. 1979, c. 146, is amended by striking out "may pay, in the amounts he considers requisite and advisable, the interest credited to the First Citizens Fund" and substituting "may pay or lend, on terms and conditions he specifies, amounts from the interest credited to the First Citizens Fund".	BY REGULATION
BILL 34 1987	18.	**Health Emergency Act** Section 9 (1) (b) of the *Health Emergency Act*, R.S.B.C. 1979, c. 162, is amended by adding ", and he may prescribe different fees for a service rendered to (i) a person who is not a "beneficiary" or "qualified person" as defined in the *Hospital Insurance Act*, or (ii) an employee who requires an emergency health service where the employer is, pursuant to an enactment, obliged to supply emergency health services" at the end.	BY REGULATION
BILL 48 1987	60.	**Insurance Amendment Act, 1980** Section 4 of the *Insurance Amendment Act, 1980*, S.B.C. 1980, c. 20, is repealed.	BY REGULATION
	61.	Section 14 (a) that enacts section 357 (1) (h) of the *Insurance Act* is amended by striking out "provincial company" and substituting "Provincial insurer".	
BILL 14 1987	9.	**Insurance Corporation Act** Section 21 (2) of the *Insurance Corporation Act*, R.S.B.C. 1979, c. 201, is amended by striking out "by the Comptroller General, or".	JUN 26 1987
BILL 48 1987	62.	**Insurance Corporation Act** Section 30 of the *Insurance Corporation Act*, R.S.B.C. 1979, c. 201, is amended by striking out "insurance company" and substituting "insurer".	BY REGULATION
BILL 59 1987	11.	**Investment Contract Act** The *Investment Contract Act*, R.S.B.C. 1979, c. 207, is repealed.	BY REGULATION

Appendix "B"

B.C. Reg. 239/82 Filed June 2, 1982
O.C. 1030/82

Health Emergency Act

EMERGENCY MEDICAL ASSISTANTS REGULATION

[includes amendments up to B.C. Reg. 26/88]

[Consolidated February 29, 1988]

Interpretation

1. (1) In this regulation

"Act" means *Health Emergency Act*;

"advanced EMA" means an EMA whose category of licence signifies that he has successfully completed training under advanced programs and passed the necessary examinations;

"advanced programs" means the teaching of the advanced medical procedures described in Schedules F to I;

"ALS" means advanced life support;

"ALS I Attendant" and **"ALS II Attendant"** means an ALS attendant trained to level I or II respectively;

"EMA" means emergency medical assistant;

(2) Reference to a licence is a reference to a valid and subsisting licence.

[am. B.C. Reg. 281/84, s. 1.]

Categories of licence

2. EMA licences issued by the commission under the Act shall be classified into the categories described in Schedule A.

Issue of licence

3. No person shall be licensed in any category set out in Schedule A unless that person has the appropriate qualifications set out in Schedule B, has completed the required training set out in Schedules C to I and has passed the required examinations for the category of licence sought.

Approved training courses

4. The training and examinations required for each category of licence or for an intravenous endorsement shall be given by persons or organizations with whom or with which the commission has entered into an agreement or arrangement under section 4 or 5 of the Act.

[am. B.C. Reg. 281/84, s. 2.]

Register of licensees

5. The name and other particulars, including licence number, of each person who is issued an EMA licence shall be entered in the register maintained by the commission.

Licence subject to conditions

6. Subject to section 6 of the Act, the commission may endorse on a licence of any category such conditions respecting the performance of emergency procedures as the commission considers necessary in the public interest.

Term of EMA III licence

7. (1) Every EMA II and EMA III licence expires 5 years after the day the licensee's name was entered on the register, or on the day the commission endorses on the licence, whichever is the earlier.

(2) On application for renewal of a licence that is due to expire under subsection (1), the licensee shall return the licence to the commission.

[am. B.C. Regs. 281/84, s. 3; 26/88, s. (a).]

Expiry of licence of any category

8. (1) Notwithstanding section 7, where a person who holds an EMA licence of any category has not been actively employed in the Province as an EMA for a continuous period of 12 months, his licence expires at the end of the 12 month period.

(2) An EMA licence that expires under this section may be renewed where the licensee satisfies the commission of his fitness to be relicensed.

Condition of licence and endorsement

8.1 It is a condition of every EMA II or EMA III licence and of an intravenous endorsement that the holder will undertake and successfully complete such course of study or training as may be fixed by the commission for that licence or endorsement.

[en. B.C. Reg. 341/83, s. 1; am. B.C. Reg. 281/84, s. 4.]

Qualifying for endorsement

8.2 An EMA licensee does not qualify for training for an intravenous endorsement until he has held an EMA II licence for not less than 3 years.

[en. B.C. Reg. 281/84, s. 5.]

Condition of endorsement

8.3 It is a condition of every intravenous endorsement on an EMA II licence that the licensee will successfully perform at least 20 intravenous starts during each successive 12 month period following the date of the endorsement.

[en. B.C. Reg. 281/84, s. 5.]

Return of cancelled or suspended licence

9. Where an EMA licence is cancelled or suspended, or has expired, the licensee shall, within 48 hours after being notified, return the licence to the commission and the commission shall cause the licensee's name and other particulars to be struck from the register.

Reinstatement of licence

10. Where an EMA licence is reinstated following cancellation or suspension, the commission shall cause the name and other particulars, including the licence number, to be re-entered in the register.

Qualifying for advanced programs

11. In order to qualify for training in an advanced program, an EMA licensee shall

(a) pass an entrance examination for the appropriate category, and
(b) possess relevant experience recognized by the commission.

Local medical co-ordinator

12. Where a medical practitioner is appointed under section 4 (2) of the Act to carry out in a community the duties and functions of the commission, including those under section 5 (f), the medical practitioner, to be known as the local medical co-ordinator, shall

(a) participate in training programs,
(b) participate in the selection of applicants for training in advanced programs,
(c) liaise with the local hospital and local medical community,
(d) recommend
    (i) the issue of EMA licences to persons who have the appropriate qualifications, have completed the appropriate training and have passed the necessary examinations, and
    (ii) the cancellation or suspension of EMA licences where cause is shown,
(e) provide upgrading training to ensure that a high standard of competence is maintained by EMA licensees,
(f) supervise the use of advanced medical procedures, and
(g) ensure that a high quality of service is provided and maintained in the community by the local EMA licensees appropriate to their training.

Performing advanced skills

13. Subject to section 6 of the Act, an advanced EMA shall

(a) perform an advanced medical procedure in the manner required by the local medical co-ordinator,
(b) where he has not been in active practice in his category during the previous 3 months, pass an assessment examination before performing an advanced medical procedure,
(c) complete the upgrading programs as required for his category of licence, and

(d) pass examinations required by the commission at intervals not exceeding 5 years to ensure continued competence at the level of training required for his category of licence.
[am. B.C. Reg. 26/88 s. (b).]

Offences

14. An EMA who contravenes section 9 commits an offence and is liable to a penalty not greater than the penalties provided in the *Offence Act*.

SCHEDULE A

EMA LICENCE CATEGORIES

EMA I: This category of licence signifies that the licensee has the appropriate qualifications set out in Schedule B, has completed the required training for an EMA I licence set out in Schedule C and has passed the necessary examinations.

EMA II: This category of licence signifies that the licensee
- (a) has the appropriate qualifications set out in Schedule B,
- (b) has completed the required training for an EMA I and EMA II licence set out in Schedules C and D and has passed the necessary examinations, and
- (c) where an intravenous endorsement is on the licence, has completed the required training for the endorsement set out in Schedule E.

EMA III: This category of licence signifies that the licensee
- (a) has the appropriate qualifications set out in Schedule B,
- (b) has completed the required training for EMA I and EMA II licence set out in Schedules C, D and E and has passed the necessary examinations, and
- (c) has completed the ALS training course for an EMA III licence in one or more of the following and passed the necessary examinations:
  - (i) for ALS I Attendant as set out in Schedule F;
  - (ii) for ALS II Attendant as set out in Schedule G;
  - (iii) for Infant Transport Attendant as set out in Schedule H;
  - (iv) for Experimental Category as set out in Schedule I.

[am. B.C. Reg. 281/84, s. 6.]

SCHEDULE B

LICENCE QUALIFICATIONS

1. For an EMA I licence:

(a) a valid and subsisting Industrial First Aid Certificate issued by the Workers' Compensation Board;
(b) a Class 4 driver's licence issued by the Motor Vehicle Branch.

2. For an EMA II or EMA III licence:
(a) the qualifications set out in section 1 (b);
(b) current employment with the commission;
(c) completion of at least 25 ambulance calls.
[am. B.C. Reg. 281/84, s. 7.]

3. ***Repealed.*** [B.C. Reg. 281/84, s. 8.]

SCHEDULE C

EMA I TRAINING REQUIREMENTS

1. Length of training course - 80 hours.

2. Course content:
(a) safe lifting and specific types of lifts used in the ambulance service;
(b) use, care and maintenance of ambulance equipment;
(c) forms of technical communication within the ambulance service as well as approaches to inter-personal communications in an ambulance setting;
(d) theory of safe driving and regulations governing driving and practical exposure to emergency driving conditions;
(e) knowledge of anatomy and physiology, such that knowledge of surface features will support patient assessment and treatment skills;
(f) assessment of the situation surrounding a call for service and the extent of a person's injury and reporting this information clearly in accordance with standard medical guidelines.

SCHEDULE D

EMA II TRAINING REQUIREMENTS

1. Length of training course - 240 hours.

2. Course content:
(a) anatomy, physiology, pathology and pharmacology, as they relate to patient assessment, management and treatment of illnesses or injuries with respect to the following areas of study:
  (i) cardiology;
  (ii) respirology;

(iii) head injuries and spinal cord;

(iv) medical emergencies, including coronary failure (myocardiac infarction, angina, conjestive heartfailure), diabetes, communicable diseases, household poisons, substance abuse and convulsions;

(v) environmental emergencies, including heat cramps, heat exhaustion, heat stroke, burns, frostbite, hypothermia and near drowning;

(vi) childbirth and common pediatrics;

(b) knowledge of and practical experience in basic rescue and/or extrication of sick or injured patients;

(c) the general study of and practical experience in ambulance work including care of the elderly, extended transfer, psychology of intervention (abusive or hostile individuals), care of the dead, infection control, medical-legal aspects of ambulance work, police, fire, ambulance inter-service and care of patients suffering from acute abdominal illnesses or injuries;

(d) filing standardized reports, in a form fixed by the commission, with the receiving hospital and the commission.

[am. B.C. Reg. 281/84, s. 9.]

SCHEDULE E

EMA II INTRAVENOUS ENDORSEMENT: TRAINING REQUIREMENTS

[en. B.C. Reg. 281/84, s. 10.]

1. Length of training course – a minimum of 30 days, including

(a) a minimum of 25 supervised intravenous starts in a hospital approved by the commission for the training course, and

(b) a 10 hour didactic and practical session the format of which shall be determined by the commission.

2. Course content:

(a) performing a critical examination of patients suffering from traumatic injuries, and making a reasonable diagnosis;

(b) beginning an intravenous infusion;

(c) administering intravenously solutions containing nutrients or electrolytes as required by the clinical situation.

SCHEDULE F

EMA III – ALS I TRAINING REQUIREMENTS

1. Length of training course - 24 weeks.

2. Course content:

(a) recognition of common life threatening cardiac dysrhythmias;

(b) recognition of impending or actual cardiac arrest and initiating therapy according to the Canadian Heart Association guidelines for Advanced Cardiac Life Support;

(c) operation of a D.C. Defibrillator to treat patients in cardiac arrest;

(d) management of an airway in unconscious victims, including the need for and use of endotracheal intubation;

(e) effective communication by radio with the physician and/or hospital departments;

(f) understanding the effects of and administering the drugs that the local medical co-ordinator has determined are appropriate for the treatment of patients in cardiac arrest;

(g) understanding the effects of those drugs required to eliminate life threatening cardiac dysrhythmias and the administration of them under the direction of a medical practitioner.

SCHEDULE G

EMA III – ALS II TRAINING REQUIREMENTS

1. Length of training course - 24 weeks.

2. Course content:

(a) recognition and interpretation of cardiac dysrhythmias and understanding the principles of therapy for life threatening cardiac situations;

(b) recognition of various forms of acute respiratory failure and understanding the therapy for life threatening respiratory disorders;

(c) treating those situations outlined in paragraphs (a) and (b) by appropriate techniques including the administration of the appropriate drugs designated by the local medical co-ordinator;

(d) operation of a D.C. Defibrillator under appropriate life threatening conditions;

(e) receiving directions on administering drugs from a medical practitioner by radio or telephone;

(f) treatment of other life threatening disorders as directed by a medical practitioner with due attention to current medical standards and patient safety.

SCHEDULE H

EMA III – INFANT TRANSPORT ATTENDANTS TRAINING REQUIREMENTS

1. Length of training course - 18 months.

2. Course content:

(a) recognition of normal and abnormal perinatal (obstetrics and neonatal) care;
(b) collection of historic information and performance of a physical assessment on both normal and sick full term and preterm infants;
(c) interpretation and effective communication of the information in paragraphs (a) and (b) to medical and nursing staff in the appropriate newborn unit;
(d) sensitive and appropriate communication of infant's problems to the parents in the referral hospital;
(e) initiation of stabilization or emergency treatment prior to or during transportation of an infant with or without the assistance or direction of other health care professionals;
(f) demonstration of competency in the operation of all equipment required to support sick infants;
(g) understanding and management of transport related problems with respect to land, sea or air transports.

SCHEDULE I

EMA III – EXPERIMENTAL CATEGORY TRAINING REQUIREMENTS

1. Length of training course to be specified.

2. Course Content: This category shall be used by the commission to include those programs currently in development. Programs in the Experimental Category must be in this category for a limited period of time only, which time shall be specified by the commission.

[Provisions of the *Health Emergency Act* relevant to the enactment of this regulation: section 9 (1)]

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Appendix "C"

Justice Institute of British Columbia

Emergency Health Services Academy

THE PROFESSIONAL FIRST RESPONDER

A Discussion Paper
prepared by:

Tony Williams, Director
Emergency Health Services Academy

and

Paul Smith, Director
Fire Academy

BACKGROUND

The Professional First Responder (PFR) is the first link in a chain which includes a variety of professional rescue and hospital personnel. Roles often overlap and become confusing leading to uncertainty. Often, physical locations help delineate these roles (between hospital and pre-hospital personnel). Even then some role overlap and confusion can exist. Where physical environments do not delineate role responsibilities, and every situation has unique features to it, the potential for confusion is even greater.

In the ideal situation, the PFR is able to manage the patient for varying lengths of time. When ambulance personnel arrive the PFRs are then able to become skilled and valuable assistants to the Emergency Medical Assistants (EMAs).

THE PROBLEM:

Until now the training available to Professional First Responders has not helped resolve this role confusion. The training available is either designed for public (or industrial) first aider, or designed specifically for ambulance personnel. None of these programs addresses the specific needs of the Professional First Responder. As a result, if the PFRs receive only general or industrial first aid training their approach did not fit with that of the professional Ambulance Service. On the other hand, if they are trained to the level of an EMA, then they are expected to perform at a level equal to someone whose primary duties are emergency medical care. Both levels of training therefore, are frustrating for the PFR and for the Emergency Medical Assistants, because the training does not specifically address the functions of a first responder.

THE SOLUTION:

The solution to this problem is two-fold. Professional First Responders and Emergency Medical Assistants must recognize that role confusion will occur when rescue personnel, emergency medical services and hospital staff are quickly assembled into a team and expected to work in concert under stressful circumstances. Accepting that some role confusion and overlap is inevitable, and like sports teams, that these can be minimized through review and practice, is the first and most important step in the solution.

The second part of the solution is the development of a training program for Professional First Responders which is targeted at the specific work they perform. Levelled between the general/industrial first aid course and the EMA 1 course, it must be developed by PFRs and EMAs together. An important feature of the program's design must be the ability to adapt the program to meet the needs of professional first responders in different communities. To this end the program must be build around a core and supplemented by several specialty or more advanced modules.

With the Academies of the Professional First Responders and Emergency Medical Assistants located at the Justice Institute, a common physical ground already exists. An added benefit is the collective educational expertise available to help these practicing professionals develop their ideas.

THE REWARDS:

For the first time we will recognize that the Professional First Responder is not a general first aider, or a professional ambulance person, but someone with a unique and special role to play that is secondary to other primary duties. If Firefighters, Peace Officers and Emergency Medical Assistants recognize this role and collectively develop the program, then it will help them work together in the field by minimizing role confusion and maximizing each other's contribution. The ultimate reward will be and even higher quality of emergency care provided to the citizens of British Columbia.

Tony Williams, Director
Emergency Health Services Academy.
:tw
March 21, 1989

Paul Smith, Director
Fire Academy.

Justice Institute of British Columbia

Emergency Health Services Academy

THE PROFESSIONAL FIRST RESPONDER

PROPOSED PROJECT PLAN:

The project falls into three phases: Identifying the specific role of the first responder, developing and piloting a training course and launching the program provincially. The course may included self- directed learning materials, skills workshops and an evaluation. Students would be taught and evaluated by a mixture of PFRs and EMAs who would make up an instructor network trained by the Academies.

PHASE 1:	**TIME FRAME**	**COST**
Establish an internal advisory committee (IVC) with representation from the field, management, union and training. Follow this with a fast track needs assessment using a third party expert.	4-6 weeks	$4,000 Shared by Fire and Ambulance Servic
PHASE 2:		
Design and develop a training program. Validate it internally via the IAC and externally to carefully selected representatives of the major services. Implement and evaluate a pilot project.	20 weeks (5-6 months)	$50,000 Shared equally by the and Ambulance Serv

PHASE 3: Launch the program provincially. Establish criteria and evaluation periods for review.	Approximately six months from the project start date.	Costs to be shared by agencies according t nature of their join involvement: e.g. F Service covering stu support and course c while Ambulance Ser contributingexamin

Tony Williams, Director
Emergency Health Services Academy.
:tw

Paul Smith, Director
Fire Academy.

Appendix "D"

PRE-HOSPITAL EMERGENCY CARE

A POSITION REPORT PREPARED FOR
A
PROVINCIAL ENQUIRY
REQUESTED BY
THE MINISTRY OF THE SOLICITOR GENERAL OF B.C.
TO
REVIEW FIRE AND AMBULANCE
PRE-HOSPITAL EMERGENCY SERVICES
IN
THE PROVINCE OF BRITISH COLUMBIA
PREPARED JOINTLY BY

THE FIRE CHIEFS ASSOCIATION OF BRITISH COLUMBIA

AND

THE GREATER VANCOUVER REGIONAL DISTRICT FIRE CHIEFS' ASSOCIATION

JUNE 16, 1989

THE ENQUIRER IS MR. J.V. CAIN, BA, LL.B, CHIEF CORONER, PROVINCE OF BRITISH COLUMBIA

PURPOSE

The purpose of this report is to formally provide information to the Enquirer about the current status of pre-hospital emergency care and to make recommendations to improve the level of emergency medical service throughout the province.

BACKGROUND

The subject of pre-hospital emergency medical care has a long and varied history throughout the lower-mainland, the greater Victoria area and the remaining sectors of the province.

"First-aid response" to citizens who were suffering from heart attacks, strokes, motor-vehicle accident injuries, drownings, suicides, gunshot wounds, accidental falls, poisonings, industrial accidents, domestic violence and a myriad host of other types of medical emergencies were primarily done by the local fire departments in the various cities and communities of the province. In many areas where there was no fire department available, the local R.C.M.P. or municipal police constable would provide (if possible) the emergency response and assistance to the injured patient.

Historically in North America, the Fire Service has been the recognized agency from which a citizen could summon assistance when an unexpected medical problem occurred. The mid 1800s saw the transition from "company-owned" insurance fire departments to municipally funded and operated fire forces. With that change came the gradual growth of full-time or composite (career and volunteer) fire departments in the urban and rural communities and a greater public awareness that the firestation was a good place to call to get help for almost anything - from a blazing apartment fire to a cat on a telephone pole; from a cardiac arrest to a cut finger, the firefighter was a helper in time of need.

This "first-aid" role or "inhalator" service continued as a secondary function to the principal reason for having a fire department. After the second world war, the priorities started to change. With the advent of more sophisticated and medically accepted life-support equipment, techniques and training, the role of the civilian para-medic emerged.

In order to upgrade patient care to a more acceptable level of service, fire personnel became involved in this para-medic phenomena which was gradually moving across the continent. Medical authorities realized that the concepts developed during the war to sustain the combat soldiers life after serious trauma could in fact be the vital difference in emergency patient care for the citizen who collapses on the street, in an office complex or in a private home.

However, the total pre-hospital needs of the patient were and still are basically two-fold:

1. quick response to the accident scene to implement the required medical treatment.
2. the transportation of the patient to hospital facilities while continuing the same vital level of emergency treatment.

Most fire departments were not in the transportation (ambulance) business. Although there were some volunteer ambulance societies operating under the umbrella of the local fire department, the majority of ambulances were either privately owned or were an adjunct facility of the local hospital. The ambulance work load was primarily non-emergency patient transport, supplemented by requests to attend the emergency scene of an accident to render assistance to the "first responder" who was already there and to take the patient to the nearest emergency ward.

The availability of an ambulance was the major problem in this two-step process. Hospitals were phasing out their ambulances because of the ever-present pressures of budget resources and the inability to properly staff a 24 hour agency that could quickly respond to the outside requests for help. Municipal borders and jurisdictional disputes over who should pay for what also contributed to the demise of the hospital ambulance.

As the hospital ambulances decreased, the number of private ambulance companies increased but they too faced the same economic realities that the hospitals had already come to grips with. Staffing, equipment and training costs could not match a publicly accepted patient per call charge. Over a period of years, the quality of service of the private companies gradually deteriorated. Not only were there longer delays in waiting for an ambulance to arrive, the level of staffing competence also became obvious at the emergency scene. As foundering companies went bankrupt and closed their doors, new ambulance companies would open for business (sometimes the same people under a new catchy name) and the no-win anomalies of costs vs service level continued to impact the patient who needed a better model of care.

Out of this worsening situation came a more effective delivery system. During the 1960s, many fire departments developed a total "Medic-One" program that encompassed a complete package of pre-hospital care. This package included emergency patient (ambulance) transport by fire service personnel and at the same time, the program instituted an improved level of fire department paramedic involvement in a "layering" system of response that greatly enhanced the survival rate of patients suffering from life-threatening incidents including acute cardio-pulmonary arrests. In North America today, there are many excellent examples of the "Medic-One" program being successfully operated by fire departments with cost-effective results. Miami, Houston and Seattle are three examples worth noting that presently deliver a better model.

In British Columbia, this evolutionary process was slower but the forementioned problems were equally as bad. During 1973, the B.C. Fire Service had the opportunity to develop similar "Medic-One" programs in their respective communities with designated financial assistance from the newly elected provincial government. However, the Fire Service had mixed opinions about this initiative and generally opposed the total "Medic-One" concept, opting instead to remain a one-dimensional agency. This provided an alternate opportunity to those who were advocating a separate province-wide ambulance service.

In 1974, the Emergency Health Services Commission was established with the legislative mandate to provide a better level of pre-hospital care throughout the entire province.

PRESENT STATUS

Since 1974, the provincial ambulance service and the 450 plus fire departments in the province have operated in co-existence with each other in a variety of inter-faced relationships. This level of interaction depended on the distinct characteristics of urban and rural settings and the structure of the local department. The financial pressures of service level delivery have essentially been the same for E.H.S.C. as they were for the hospital and private carriers prior to 1974.

In the major centers of population, fire departments were and still are utilized as "first-responders" to offset glaring E.H.S.C. deficiencies in establishing and maintaining the necessary critical response times that are absolutely necessary to ensure adequate patient survival. Had these fire departments not continued to provide this "first-responder" service for the thousands of annual requests for assistance, E.H.S.C. would have been faced with enormous start-up costs for equipment, housing, training and manpower. To this day, most fire departments receive little or no financial compensation from the provincial government for their strategic role as "first-responders" and E.H.S.C. simply cannot provide the required service level within their existing budget resources without the help of the fire service.

Some mid-sized cities and rural communities experienced the development of "contract" ambulance services which were fulfilled by the local fire department and although this model also experienced some problems in maintaining an acceptable performance standard in applying patient care skills, it has generally proved to be a very cost-effective delivery method, especially for the provincial government.

The smaller townships where only volunteer fire-forces were available could not provide the quick-response infrastructure necessary to mitigate life-threatening trauma and medical incidents. Although there is some beneficial assistance from air-ambulance resources, most of these communities are still not serviced by E.H.S.C. ambulances even though the government's original mandate was to expand to these areas of need with an appropriate and life-sustaining level of response.

INTER-AGENCY PROTOCOLS

The harmony between fire service and ambulance personnel has been a roller-coaster of good and bad experiences. Prior to 1974, inter-agency rivalry many times deteriorated to open hostilities and the by-product of these occurrences produced a lower level of care to the citizen who really did not expect to receive this dichotomy of attitude. Fire Service personnel were generally better trained in first-aid skills than the privately operated ambulance personnel. This was more common in the larger urban areas. The fire officer, without legislative or by-law authority, was "in-charge" of the accident scene. This jurisdictional issue also contributed to the decaying relationship. In addition, ambulance personnel were constantly reminded (by words and the evolutionary process) that the fire service each year was moving closer to the "Medic-One" status and this prospect only helped to alienate the agencies further apart.

Since 1974, the situation has been reversed. The level of training and certification of E.H.S.C. ambulance personnel far surpasses that of the fire service and with the exception of rescue and extrication, the fire officer is no longer in charge. Provincial legislation now gives patient-care control to E.H.S.C. Although there has been some general improvement in field-operation compatibility, pockets of jealousies still caused sporadic conflict.

One of the major concerns of the fire service has been the policy and procedures of E.H.S.C. dispatching which in itself was undergoing a significant transition to a centralized configuration that would facilitate regional needs. In this process, fire departments became increasingly more dependent on E.H.S.C. notification that their services were required as a "first-responder". Coupled with this dependency was a growing community awareness that E.H.S.C. was the agency to call for medical help.

During the first decade of E.H.S.C. operation, the call-load for fire department "first-responder" assistance diminished with the urban centres reflecting the greater reductions. Many Fire Chiefs questioned this change-over process as numerous complaints of ambulance delays became more prevalent. In an attempt to correct this situation, formal dispatching protocols were discussed and finally implemented. These agreements varied between certain provincial regions but one of the most generic procedures was the "three minute" rule. This essentially meant that if E.H.S.C. could not be on-scene at the medical emergency within three minutes, then the local fire department would be called as the "first-responder".

E.H.S.C. called this a "layered response" system but in fact it was not a layered or over-lapped system at all in the same manner that the "Medic-One" systems were being used so successfully in many other cities. A "layered response" system means that several layers of help all respond at the same time to assist the critical medical needs of the patient. Formal emergency agencies such as fire, ambulance and police would be simultaneously dispatched to the call. Fire departments themselves would sub-layer by first sending the closest firetruck to the scene and at the same time dispatch a mobile rescue/paramedic unit. The fundamental reason for this "layering" was to ensure that someone did in fact arrive at the scene as fast as possible. Increasing traffic congestion, inability to respond and mechanical breakdown were some of the variable concerns that could impact patient care and survival. The first emergency crew to arrive would evaluate the situation and diagnose the patient's needs. If treatment was necessary, it would be immediately implemented without overwhelming the patient or the incident scene with excessive emergency personnel. If no or lesser treatment was required, other responding units would be cancelled via improved radio communications and returned to their formal duties. This system ensures optimal emergency response. Wherever this system is used, the results have unquestionably been outstanding. In fact, some of the "Medic-One" cities have extended the layering principle into the total community. Postal employees, bus drivers, taxi drivers, garbage collectors, government (outside) inspectors, waitresses, retail clerks or any of the more visible occupations who have by the nature of their work, more opportunity to be closer to the general public and can immediately implement cardio-pulmonary resuscitation (CPR). This complete "layering" of community and public-safety agencies has never been accomplished in British Columbia, although some areas, with the help of St. John's Ambulance and other community teaching groups have made some successes in raising the proficiency level of the general public.

In the E.H.S.C. semi-layered system, some of the protocol agreements also tried to govern other response criteria such as motor vehicle accidents, maternity calls, and prioritizing procedures. Generally, the agreements worked reasonably well but the "three minute" rule was and still is almost impossible to accurately monitor for effectiveness.

Complaints of ambulance delays continued and it was difficult to understand the logic of not responding a fire unit to a patient 1/2 block from the firestation. It was equally as hard to explain the three minute rule to the surviving family when they angrily reported that the ambulance took more than five or six minutes to get there and why was the firehall or the police not sent to help? E.H.S.C. would deny such allegations, there would be closer dispatching scrutiny for a while and then the above scenario or one similar to it would occur again.

The Fire Chiefs viewed these incidents as a serious lowering of the medical service level in the community. E.H.S.C. was caught in the complexities of growth. While trying to adhere to the protocol agreements, they were at the same time trying to clearly establish themselves as the primary agency for emergency pre-hospital care. They could not match their resources to the community need and in the process, the relationship between fire and E.H.S.C. personnel continued to deteriorate.

In the fall of 1986, the situation became worse.

A policy statement was issued by E.H.S.C. that effective January 1, 1987, all existing protocol agreements would no longer be in effect as written and the fire service would only be called on an "as-needed" basis where "life-threatening" emergencies existed. The fire service now would be almost totally removed from the "first-responder" role. The protocol criteria that had been a source of bothersome criticism to E.H.S.C. would no longer be there. E.H.S.C. could now, without any outside measurement or evaluation, control their emergency world.

The Fire Service strongly objected to this change and for very good reasons. The limited benefits existing under the prior E.H.S.C. semi-layered system were now going to be lost and the effectiveness and success of the newly announced system would be predicated by E.H.S.C. dispatchers. Based on telephone information received, the dispatcher would determine if the call was "life-threatening" and if so, then the fire service would be called. The difficulty with this system is that the dispatcher (as well-trained as he/she may be) cannot see what is actually happening at the emergency scene and must depend on the accurate assessment of the caller who most of the time is untrained in patient diagnosis.

In addition, people communicate in many different ways, especially when there may be a language barrier or encumbrance or when the emotions of the situation override definitive assessments. Many times, calls for assistance come from strangers who know nothing about the patient's medical background. A "man-down" on the street can mean a variety of causes from simple fainting to cardiac arrest. Motor Vehicle accidents with patient injuries and the additional complication of fire from unnoticed leaking fuel (especially alternate fuels such as propane and natural gas) may be incorrectly reported and many times the call comes from a location away from the accident scene where verification of information cannot be readily given.

Patient diagnosis cannot be done from a dispatch office and even the most experienced on-scene "first-responder" will at times have difficulty in accurately determining the patient's ailment, other than the fact that the person has collapsed and they need medical help without unnecessary delay.

On December 9, 1986, the G.V.R.D. Fire Chiefs Association sent a letter of protest to the regional manager of E.H.S.C. who had unilaterally made the January 1, 1987 changes in the existing protocol agreements. A series of meetings between the Fire Chiefs and E.H.S.C. regional senior staff took place early in 1987 but E.H.S.C. would not modify its position on this arbitrary policy change.

On April 9, 1987 a meeting took place at Vancouver City Hall that was attended by G.V.R.D. Fire Chiefs, G.V.R.D. City Managers, Dr. C.B. Henderson, Assistant Deputy Minister of Health, Mr. N. Baynes, Executive Director of E.H.S.C. and other regional E.H.S.C. Managers. This meeting reached a tentative agreement which set in motion a process that finally produced a new G.V.R.D. "First Responder" policy effective July 15, 1987 with additional operating protocols dated August 1, 1987. These protocols were similar to the 1984 Agreements. In addition, a joint G.V.R.D./E.H.S.C. Liaison Committee was established with specific terms of reference identified to help ensure that the interfacing of the two agencies would be more compatible.

During the next year (1987-1988), even though there were some positive attempts made to make the system work by many people at various levels of both agencies, the fundamental problems as previously described still continued to plague the new arrangements. The E.H.S.C. semi-layered system, the three minute rule, the debate of what constituted an "emergency", "floater" ambulances that tried to balance E.H.S.C. priority "stacking" and E.H.S.C. dispatching control that unfairly dictated the actual level of service to each respective community (without community or Council consent) all contributed significantly to the upheaval.

Charges and counter-charges of protocol violations were growing, ambulance delays continued as non-emergency transport work was taking emergency ambulances out of their normal (and familiar) areas of coverage. "Floater" ambulances or other units from adjacent districts or municipalities were used as secondary back-up but this impacted the efficiency of knowing the streets and topography of the respective community. The Fire Service was completely frustrated by the attitudes of some E.H.S.C. management personnel who persisted in blaming the Fire Service for all the problems that were being encountered. In order to establish some investigative credibility to these exchanging accusations of protocol infractions, the Liaison Committee established a written inter-agency enquiry report form that would require documented data of what the perceived violation was about and what action was recommended and taken to correct those identified problems. After five months of usage, E.H.S.C. advised the Fire Service that they were no longer going to respond to any further enquiry reports as they felt they were not relevant to the protocol agreement. The Fire Service did not agree. The actual fact of the matter was that for the first time, written documented complaints were being accumulated that would prove what the Fire Service had been saying for years - E.H.S.C. did not have the resources to provide satisfactory response times and could not live up to the requirements of the three minute rule. E.H.S.C. officials only wanted problems satisfied by telephone notification. After another series of meetings, the enquiry report form (at the insistence of the Fire Chiefs) remained in place.

The relationship continued with more field problems surfacing each month. On December 6, 1988, the E.H.S.C. Region 2 Supervisor circumvented the liaison committee and wrote a letter of condemnation regarding many areas of perceived failings of the Fire Service. The letter asked that RAAC (the Regional Administrative Managers' Advisory Committee of the G.V.R.D.) enforce the protocol agreement and its application on their respective fire departments.

On December 29, 1988, the G.V.R.D. Fire Chiefs Association responded by letter to these allegations and asked that RAAC either refer the incident back to the liaison committee for disposition or refer all the identified issues to the Ministry of Health to request a full independent enquiry and study regarding the whole issue of emergency pre-hospital medical care and how it is actually being delivered to the taxpayer who pays the bills for a service that is so badly fractured.

In January, 1989, at the request of the Minister of Health, the Ministry of the Solicitor General ordered an official independent enquiry to review specific events that had taken place and to look at the "global" situation of Fire and Ambulance Services in the Province.

PRIVATIZATION

During 1987, the Provincial Government initiated a program that would consider an expanded focus on privatization or "contracting out" of government services. As this program gained momentum and government agencies were closed and their services contracted to the private sector, the B.C. Ambulance Service was partially identified by various people as a possible candidate for these initiatives.

In a government publication dated March 1988, the Director of E.H.S.C. operations stated - "By reducing the non-emergency transfer load (to private ambulance companies) on our ambulances, we can achieve faster response times for emergencies."

After years of complaints from the general public and the Fire Service, E.H.S.C. finally acknowledged that they did in fact have a problem with their response times.

History started to repeat itself. The same fears of uncertainty that haunted the private ambulance service in the 1970s when the "Medic-One" fire department programs originally began similarly now caused E.H.S.C. to view the Fire Service as a threat to their security. The Fire Service did not initiate these suggested alternatives but at the same time, they never denied that there was a crying need for a better delivery model.

In retrospect, it became increasingly clear that the arbitrary policy change of January 1, 1987 made by E.H.S.C. mid-management staff was a deliberate attempt to diminish the profile of the fire department and elevate the importance of the Ambulance Service to negate the increasing arguments favoring privatization. One of the protocol requirements was an agreement that the Fire Service would eliminate all references that they were in the "inhalator business". Telephone book listings, fire department publications and all public directives were to remove the word "inhalator". The Fire Service complied and this in itself only added further community confusion as a long time tradition of emergency service now was disappearing.

The Ambulance Service Union (CUPE, Local 873) also feared privatization and viewed the Fire Service as a serious alternate threat. An aggressive campaign to degrade the abilities of the "first-responding" firefighter was implemented. Numerous Union publications with offensive cartoons depicted the Fire Service as being incompetent "yahoos" who only wanted to protect their own jobs and make "wheelbarrows" of money for contracted services were circulated. Despite letters of protest from Fire Chiefs and Fire-Union Officials, the insulting rhetoric continued and this only drove a deeper wedge between two agencies that were supposed to be working together to provide the best possible care to the patient.

The irony of what was happening culminated in a boycott and picket lines being drawn at the Justice Institute E.H.S.C. Training Academy in September, 1988. This action by CUPE 873 was to prevent two Campbell River firefighters from receiving EMA II certified training from the E.H.S.C. Academy. Campbell River is one of seven municipal fire departments in the province who legitimately operate an ambulance service for E.H.S.C. under contract with fire department personnel.

The Fire Service has for a number of years recognized that they were experiencing various deficiencies in first-aid training. The level of competence throughout the province was inconsistent and the larger departments generally fared better than the smaller ones. The B.C. Fire Chiefs Association has done considerable work in formulating a curriculum for a "first-responder" program but lack of available provincial funding has delayed any implementation and the need for a province-wide standardized level of training still exists. The skills upgrading should include the use and application of cervical immobilization devices, advanced limb splinting techniques and trauma and life-support systems and equipment. For fire departments doing contract services for E.H.S.C., the need for complete EMA II and EMA III training is even more critical.

In response to numerous Fire Service requests, E.H.S.C. reluctantly agreed to provide the necessary training under the certification criteria of the Provincial Health Act. To this day, the identified needs of the Fire Service are still lacking in both first-responder and advanced training. Meanwhile, CUPE 873 continued to highlight the firefighters "lesser" training while opposing any attempt to improve their emergency-care skills. This serious problem needs decisive action to correct an exacerbated situation that will continue to impact the level of patient care in the community.

SERVICE DELIVERY MODELS

By the provisions of the Provincial Health Act, the mandate and responsibility to provide an adequate level of pre-hospital emergency care rests exclusively with the Provincial Government and not with the Cities, municipalities and smaller communities.

There are several options in delivering this service:

1. Provide adequate operational and capital funding to E.H.S.C. so that this provincial agency can provide the necessary level of service to all areas of the province without using the services of the local fire department.

2. Under joint agreements between E.H.S.C. and the local fire department, utilize the established emergency infrastructure of the fire service by implementing one of the following service models:

a) develop new inter-agency operating protocols that will interface the two agencies wherever possible in a totally layered response system that eliminates the three-minute rule and all the corresponding problems associated with the past "semi-layered" system. These agreements and protocols could also be established on a regional basis that may permit more "tailoring" to the respective needs of the area or they can be implemented on a singular basis to the requirements of each city, municipality or town.

Additionally, there should be a funded provincial program to establish the "layering system" into high-profile occupations in the community to reduce the risk of improper or failed resuscitation and the resulting post-recovery impairment of the patient.

In addition, the Ministry of Health should establish a comprehensive "first-responder" first-aid course for the Fire Service to maintain a standardized level of patient-care skills throughout the province. Certification requirements should be included in the B.C. Health Act with training implemented at the Justice Institute of B.C. utilizing the E.H.S.C. Academy and/or the Fire Academy.

b) Continue to contract the Ambulance Service to local fire departments with adequate funding to meet the provincial service level standard. In addition, all required fire department staff must be upgraded in emergency medical care treatment that encompasses the levels of "First-responder, EMA II and EMA III without interference from CUPE - Local 873. The cost of this training, whether in-service or at the Justice Institute, should be provided by the Ministry of Health.

It should be noted that prior to the establishment of E.H.S.C., there were several fire departments in the province who were operating ambulances and delivering a higher level of service to their communities than what they are receiving today and it was achieved without the post 1974 problems of conflict and harangue.

c) Amalgamate the Fire and Ambulance Service together to formulate a comprehensive "Medic-One" program wherever the emergency infrastructure of the local fire department can accommodate such a merger and the amalgamation has the approval of the local Council. Organizational structure under this system could utilize E.H.S.C. personnel in the following work classifications:

i) Firefighter/Medic - All E.H.S.C. ambulance personnel who could meet the minimal firefighter entrance standards could be employed in a dual-purpose role with full integration into the local fire department.

ii) Ambulance Medic - E.H.S.C. ambulance personnel who were not qualified to the firefighter standard could be integrated into the local fire department but would only function in the singular role of ambulance medic.

In order to assimilate either of the two above options into an effective and co-ordinated operational work-force under fire management, it would be more advantageous to merge E.H.S.C. Union personnel into the respective Firefighter Union of that local department.

The need for adequate provincial funding to facilitate the yearly costs of such mergers would be necessary to ensure that cities or municipalities were not encumbered with expenditures of manning, housing, equipment, training and other related amalgamation expenses.

There are some Fire Chiefs who do not favour amalgamation of the two services but, there are others who consider this system as a viable option provided the many policy, contractual and organizational issues of such a merger can be effectively resolved.

In all of the above delivery options, there would be a distinct improvement in response times if non-emergency patient transport was not provided by ambulances who were strategically structured to respond only to emergency incidents. This system is primarily used in most of the "Medic-One" cities and has proven to be a very cost-effective system.

CONCLUSIONS

This report has been written to identify the problems that presently inhibit an effective delivery of pre-hospital emergency medical care to the citizen who requires that service without unnecessary delay. The co-operation and harmony between two major emergency response agencies has produced a long history of good and bad experiences. There are many reasons that have caused these unfortunate situations and this report details the root causes that have seriously impacted the dual roles of fire and ambulance personnel. Three of the major problems are the "semi-layered" response system that incorporates the inefficient "three-minute" rule, the inability of the Ambulance Service to maintain acceptable emergency response times for their ambulance units dispatched to the incident scene and the lack of operational and capital funding that seriously restricts the complete delivery of service, including the availability and funding to establish necessary training programs for fire personnel who are interfaced with the Ambulance Service.

This report also identifies a number of optional service delivery models and strongly recommends that government intervene with decisive action to implement a better system of pre-hospital emergency care. If this is not done and a "band-aid" fix-up is put forward or if no corrective measures are taken at all, then the existing system will continue to produce an unacceptable level of service to the medically impaired patient.

There is also the concern that if the Fire Service is to continue in a support role to the Provincial Ambulance Service, then there should be suitable amendments made to the Municipal Act that would allow Fire Departments to establish suitable By-Laws that would establish legal authority to fulfill their support function.

The final observation and conclusion is that although there has been many years of inter-agency conflict and dispute, there still remains an opportunity to resolve the identified problems and establish some much needed stability. Both Fire and Ambulance personnel are philosophically committed to the goal of providing optimum emergency care to the patient but the situation now requires the determination, courage and will of all parties to make serious adjustments and changes.

RECOMMENDATIONS

The Fire Chiefs' Association of British Columbia and the Greater Vancouver Fire Chiefs' Association recommend as follows:

A. THAT adequate operational and capital funding be provided by the Ministry of Health to the Provincial Ambulance Service so that this provincial agency can provide the proper and necessary level of pre-hospital emergency care to all areas of the province without using the services of the local fire department.

or

B. If local fire departments are required to supplement the Provincial Ambulance Service with resources to assist in the delivery of pre-hospital emergency care, then the local fire department should be inter-faced by using one or more of the optional delivery models as described in this report.

then

C. If the local fire department is utilized in a supplemental or contractual role to assist the Provincial Ambulance Service in delivering pre-hospital emergency care, there should be adequate funding and financial compensation to the local municipality for the provision of such service.

and

D. THAT suitable amendments be made to the Municipal Act that would enable local Councils to enact By-Laws that would establish legal authority to allow the fire department to fulfill a supplementary emergency support role to the Provincial Ambulance Service.